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Safety in Partnership Evaluation

Phase One Report: First Impressions

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1. Introduction

The aim of this report is to share with the Evaluation Project Board the evaluation team's initial response to three questions:

- What is the 'Safety in Partnership' (SiP) approach?
- How does the SiP approach sit within what is known about family support?
- How does the SiP approach sit within the expectations of child protection?

In keeping with the realist evaluation approach being followed, we are setting out for discussion our first steps towards making explicit the underlying assumptions about the approach; the theory and evidence on which it is based, the practice principles and core elements of which it is comprised and the criteria by which it should be evaluated.

The methodology for phase one of the evaluation of SiP, reported here, involved:

1. A review of the research, policy and practice literature in order to provide an overview of recent child protection and family support policy and organisational developments in Northern Ireland as the context of SiP and the theory and evidence base which underpin it as an approach;
2. Discussions with key members of staff, identified by the Western Health and Social Care Trust (WHST), to detail the constituent elements of the approach and its development within the WHST. A group discussion with two senior managers and a Principal Practitioner took place on 21st August 2012 in relation to the development of SiP within the WHST and this discussion was graphically recorded in order to provide a contemporaneous record. Individual discussions with staff members took place between 14th and 21st September focused on detailing the approach and its use in practice. The staff members spoken to in this regard included one senior manager, one Service Manager, three Social Work Managers, two Principal Practitioners and one Senior Practitioner.
3. A review of key documents related to the SiP approach and provided by the WHST. These documents included a draft handbook, training materials, correspondence and minutes and notes of meetings of groups such as the Quality Improvement Board, the Project Team and the Practice Leaders' Forum.

The report starts, in Section 2, by considering the legislative and policy context which prompted the development of SiP and which will determine its future. This is followed in Section 3 by a discussion of family support and its relationship to child protection which details the underpinning theory and evidence base for the SiP approach. Section 4 then sets out our understanding of SiP based on our discussions with staff and review of documents as outlined above. Section 5 sets out our understanding of the development of SiP within the WHST and Section 6 concludes the report.

2. Family Support and Child Protection in Northern Ireland

Northern Ireland is the smallest and youngest part of the United Kingdom (UK) and yet, over the past forty years, it has experienced greater social and political changes than any other part of the UK – not least that associated with the ‘Troubles’ and their aftermath (Fay et al., 1999). The pace of change and the new directions in lifestyles is making Northern Ireland into a much less traditional and homogenous community than it was and children’s lives reflect the richness and the risks that have come with that. Despite declining numbers, children still account for one in four of the population, many of whom are affected by the continuing deep-seated patterns of social exclusion based on living in poverty, in rural areas, in minority ethnic communities, having a disability and for those in families failing to meet their needs. The family in both its traditional and newer forms still has a central place in meeting the holistic needs of children and young people, although this is in tension with the equally apparent reality that the capacity of the family to respond to those needs is being seriously challenged. The role of the state, therefore, is to support families in the upbringing of their children, only stepping in when parents are unable or unwilling to provide the care a child requires.

The promotion of family support is not just a pragmatic response by the state to managing social change and family life. It is also a principled position in line with the global aspirations of the United Nations’ Convention on the Rights of the Child (UNCRC). Although the historic importance of the UNCRC is primarily the recognition it gives to children in their own right, it also places special emphasis on supporting the family in carrying out its caring and protective functions;

“The family, as the fundamental group of society and the natural environment for the growth and well-being of all its members and particularly children, should be afforded the necessary protection and assistance so that it can fully assume its responsibilities within the community.” (UNCRC Preamble).

The mandate for developing family support services is not only found in the UNCRC but also in UK legislation. The legal basis for the promotion of family support within Northern Ireland is found in Part IV and Schedule 2 of the Children (NI) Order 1995, along with the associated guidance and regulations. The commitment to the promotion, protection and provision for children found in the legislation is backed up by the 2006 Northern Ireland Children’s Strategy. It has at its core a vision that ‘...all children and young people living in Northern Ireland will thrive and look forward with confidence to the future’ (OFMDFM, 2006: 5).

It provides an outcomes framework that seeks to ensure all children are: healthy; enjoying, learning and achieving; living in safety and with stability; experiencing economic and environmental wellbeing; contributing positively to community and society; and living in a society which respects their rights (OFMDFM, 2006: 7). It also declares a number of core values, such as the dignity and uniqueness of children as active participants in their own lives (OFMDFM, 2006: 11) and it pledges to take forward eight themes (OFMDFM, 2006: 13) that cut across all the outcomes. In addition to the one recognising the challenges of becoming a

post-conflict society, the themes include: adopting a ‘whole-child’ approach; working in partnership, in particular with parents, carers and communities; emphasising prevention and early intervention; ensuring that the views of children and young people are routinely sought; ensuring services match needs and evidence about what works; and encouraging a rights-based approach. The document also outlines a range of mechanisms to be used to determine the success of the strategy over time, including a set of performance indicators and a number of implementation structures.

The importance of family is reinforced by *Families Matter: Supporting Families in Northern Ireland* (2009) a regional Family and Parenting Strategy. It is ‘a supporting pillar of the children and young people’s strategy’ (Department of Health, Social Services and Public Safety, 2009: 22) and has as key themes: Information for Parents and Service Planners; Access; Supporting Families and Parents; and Working Together for Families and Communities. It complements policy development in child poverty, child protection and safeguarding. The importance of early intervention and prevention is stressed;

“This strategy, in conjunction with Care Matters NI, provides an integrated approach to ensure that needs based support is provided to all children and families, and that through investment in early intervention and prevention there will be a positive impact on families and a reduction in need for higher levels of support.”

(Department of Health, Social Services and Public Safety, 2009: 20).

Family support is defined as the provision of a range of supports and services to ensure that all children and young people are given the opportunity to develop to their full potential. It aims to promote their development primarily by supporting families and strengthening communities. ‘Its focus is on early intervention, ensuring that appropriate assistance is available to families at the earliest opportunity at all levels of need’ (Department of Health, Social Services and Public safety, 2009: 18).

Despite the policy direction being firmly set for family support, the dominant concerns within child care services continue to be the protection and care of children who are at risk, the management of children beyond the control of their carers and the provision of substitute care through kinship care, foster care and residential care – in other words, a pre-occupation with ‘the deep end’.

The introduction of The Children (Northern Ireland) Order 1995 in November 1996, and the learning arising from the Department of Health’s *Messages from Research: Child Protection* (Department of Health, 1995) programme in England resulted in the issue of new child protection guidance in May 2003, *Co-operating to Safeguard Children* (Department of Health, Social Services and Public Safety, 2003). The guidance was broadly similar to *Working Together to Safeguard Children* (Department of Health et al., 1999) and set out the role and expectations of professionals and agencies in relation to the protection of children from abuse and neglect. This coincided with the publication of the review into the death of Victoria Climbié (Laming, 2003) which, whilst primarily focused on the English child protection system, held many key lessons for services and practices in Northern Ireland as

well. One of the recommendations in the inquiry report was that agencies should conduct an audit of their child protection services against the key themes identified in the inquiry. The Department of Health, Social Services and Public Safety commissioned such a review in Northern Ireland in 2004, and the subsequent audit highlighted shortcomings in a number of areas (Department of Health, Social Services and Public Safety, 2006). As a consequence the Department embarked on an inspection of child protection arrangements and services in Northern Ireland. The inspection was undertaken in five of the then eleven community Health & Social Services Trusts between 2004 and 2006. To assist with the inspection a set of draft standards were developed against which to assess services.

The findings from the inspection were similar to those from other inquiries, research and reviews conducted in Northern Ireland and elsewhere (for example, see Devaney, 2009; Hayes and Spratt, 2009; Pinkerton and Devaney, 2009). The benefit of a whole system inspection was that it confirmed what was previously suspected about the level of consistency in delivering children's services (Spratt, 2000). It revealed inconsistency in structures, roles, systems, processes and approaches.

The inspection was also critical of the quality of management of some children's services and identified poor assessment practice, a lack of critical review of cases, poor risk management and poor recording practices. There was wide acceptance of the recommendations of the report and recognition of the need for change to fully realise the benefits of the integrated health and social care system for safeguarding children in Northern Ireland. It was also acknowledged that there was a real opportunity to achieve coherence and consistency in approaches due to the size of Northern Ireland and the existing close working relationships between agencies.

The inspection report, *Our Children and Young People Our Shared Responsibility* (Department of Health, Social Services and Public Safety, 2006) made 77 recommendations. It was hoped that these would:

- Improve arrangements for safeguarding children;
- Increase public awareness and confidence in this important area;
- Enhance professional practice, multi-disciplinary and inter-agency working and service provision;
- Inform policy development with regard to safeguarding children and young people.

Whilst there was acceptance of the conclusions of the inspection, there was also a criticism of the inspection process itself. The inspection was originally scheduled to be completed within a year, but the illness of one of the key members of the inspection team resulted in the review taking nearly three years to be completed. In this time a number of factors arose that impacted on the remit and conduct of the inspection (Department of Health, Social Services and Public Safety, 2006). For example, in September 2004 the Northern Ireland Commissioner for Children and Young People (NICCY) raised with the Minister the issue of the number of unallocated child care cases held by social services. As such the inspection team were asked to take this issue into account and to assess a number of unallocated/

waiting list cases to ascertain if they had been screened appropriately to confirm the absence of child protection or other issues warranting urgent allocation. In 2005 concerns about the interface between residential and fieldwork services resulted in three of these five Health & Social Services Trusts having additional inspections undertaken of their children's residential homes, (including the legacy Foyle and Sperrin Lakeland Trusts) exploring the issue of how risks that children posed to other young people in residential care were managed.

In total the inspection process resulted in 792 local recommendations for the five Trusts inspected. The legacy Foyle Trust had 149 recommendations to address, while the legacy Sperrin Lakeland Trust had a further 185 recommendations, in addition to the seventy-seven regional recommendations. Beyond the sheer number of recommendations that each organisation had to deal with was the fact that large numbers of action points dealt with similar issues, there was an overlap between local and regional recommendations, and the recommendations were sufficiently differentiated to require different action to be taken. This had the effect of creating a whole industry of activity involved in developing action plans and implementing changes, causing an unparalleled level of change at a time of significant structural change within Northern Ireland. The newly formed Western HSC Trust established the 'Improving Quality Together Project Board' to take forward these 411 recommendations in a co-ordinated approach.

Reform of Public Administration

In 2007 public services in Northern Ireland underwent their most significant reform since the imposition of direct rule in 1972. The Review of Public Administration was designed to reduce bureaucracy and administration costs, and renew local government and provide greater consistency in the delivery of public services to the Northern Ireland population. Health and Social Care was the first sector to reform its structures, with the four Health and Social Services Boards replaced by one Health and Social Care Board as the commissioner of services, and eighteen hospital and community health and social services Trusts replaced by five integrated Health and Social Care Trusts providing a mixture of community and hospital based services. The Sperrin Lakeland Trust and the Foyle Trust were merged into the new Western HSC Trust, which became operational on 1st April 2007.

The Reform Implementation Team

As a consequence of the child protection inspection, the Minister for Health and Social Services endorsed the commencement of a reform programme led by the Department of Health, Social Services and Public Safety through the establishment of a Reform Implementation Team (<http://www.dhsspsni.gov.uk/index/ssi/oss-childrens-services.htm>). The Team was designed to take forward the implementation of the recommendations of the child protection inspection and the associated developments required to improve services to children. This included bringing forward a Safeguarding Board for Northern Ireland to replace the four existing Area Child Protection Committees, supported by Independent Local Safeguarding Panels coterminous with each of the five new Trust areas.

The vision statement for the work of the Reform Implementation Team was:

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“To create children’s services that are acknowledged as being high quality, accessible, well managed and appropriately meeting need with a focus on improving outcomes for children.”

The process was managed as a project overseen by a Project Reference Group with the remit to oversee the implementation process and to endorse actions on a multi-agency basis. The group comprised senior managers from all the key agencies, with representatives from the Department of Health, Social Services and Public Safety, the Department of Education, the Police Service of Northern Ireland, the Probation Board for Northern Ireland, the Youth Justice Agency and the voluntary sector. A multi-agency Implementation Group was established with responsibility for taking forward the actions required to implement the recommendations through a series of task specific work streams. These have evolved as key actions have been achieved and new areas of development work have been identified and agreed.

Funding was made available to each Health and Social Care Trust, as the lead agency, to recruit a Change Co-ordinator. This provided a necessary resource to support the local Project Teams within each Trust to co-ordinate actions and implement the recommendations on a multi-agency basis at a local level, ensuring that actions were taken forward within the agreed timescales. Within the new Western HSC Trust the Change Co-ordinator was instrumental in the initial development and roll-out of Safety in Partnership.

RQIA

Under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, the NI Assembly established the Regulatory and Quality Improvement Authority, an independent body under the Department of Health, Social Services and Public Safety responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

In May 2008, RQIA began a two year review of child protection services in Northern Ireland. The review focused on selected recommendations from the report *Our Children and Young People Our Shared Responsibility* (Department of Health, Social Services and Public Safety, 2006). Where relevant, it also took into account recommendations from the Independent Inquiry Panel into the deaths of Madeleine and Lauren O’Neill; referred to as the O’Neill Report (Western and Eastern Health and Social Services Boards, 2007), and the Independent Report into agency involvement with Mr Arthur McElhill, Ms Lorraine McGovern and their children; referred to as the Toner Report (Department of Health, Social Services and Public Safety, 2008).

Due to the size and scale of child protection services in Northern Ireland, and the number of recommendations in the SSI Overview Report, the review was sub-divided into the following five discrete stages looking at particular aspects of the governance and delivery of services;

- Stage 1 - Corporate leadership and accountability
- Stage 2 - The views of service users
- Stage 3 - Quality of record keeping
- Stage 4 - Quality assurance, managing performance of service and access to services
- Stage 5 - Interagency communication at point of referral

The review by RQIA aimed to:

1. Evaluate the implementation of identified recommendations of the SSI Overview Report within HSC Trusts;
2. Inform on the actions being taken by HSC trusts to implement relevant Reform Implementation Team (RIT) policy directives and to apply the relevant RIT guidance documents (relevant to those recommendations of the SSI Overview Report under review);
3. Evaluate the implementation of key recommendations (relevant to those recommendations of the SSI Overview Report under review) of the Report of the Independent Inquiry Panel into the deaths of Madeleine and Lauren O'Neill which relate to child protection;
4. Inform on the actions being taken by HSS Boards with regard to the transition arrangements in place to ensure continuity of child protection services;
5. Highlight for review in the future and, as appropriate, any other relevant issues which may arise during the course of the review.

Progress Since the RQIA Review

Following the conclusion of the review, RQIA requested that HSC Trusts complete and submit to RQIA a template outlining the progress achieved against each of the recommendations made during the five stages of the review. Following a review of these responses, RQIA were satisfied that all recommendations were fully addressed or in the process of being addressed (RQIA, 2011).

This coincided with the then Minister for Health, Social Services and Public Safety asking Mr Henry Toner, QC to revisit the Western HSC Trust in June 2010 to check on the progress made in implementing the recommendations from his earlier review of the Trust's handling of referrals in respect of Mr Arthur McElhill and family (Department of Health, Social Services and Public Safety, 2008). This follow up review (Department of Health, Social Services and Public Safety, 2010) noted that the Trust was making substantive progress in addressing the recommendations from the earlier review. The review noted that the Trust had introduced the 'Safety in Partnership' approach in response to one of the recommendations, although some caution was expressed about the need to ensure that this approach was used within the existing range of policies and procedures rather than as an alternative.

Since the review the Health and Social Care Board has progressed a number of initiatives which address child protection arrangements across all HSC Trusts. These have remained in place until the establishment of the Safeguarding Board for Northern Ireland. The RQIA state that the establishment of the Safeguarding Board for Northern Ireland will fundamentally change the governance of child protection services across Northern Ireland (RQIA, 2011). The Safeguarding Board for Northern Ireland was launched on 18th September 2012.

3. Family Support, Solution Focused Practice and Signs of Safety

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Safety in Partnership (SiP) can be seen as a recent response to the continuing challenge of developing child welfare programmes and practices that express the legislative intention of the Children Order to promote family support whilst ensuring child protection. As with all such attempts, SiP has to address a number of key challenges which were identified by the Family Support in Northern Ireland research carried out in the 1990s by the Centre for Child Care Research at Queen's University Belfast. Part II of that research focused explicitly on service delivery; carrying out five process evaluations of settings representing 'the range of family support possibilities as theoretically constructed in the previous stage of the study based on the [Hardiker] four levels of Prevention (Higgins et al., 1998: 5). That research recognised the importance of aspects of existing operational policy, organisational structures and child welfare practice in providing the foundations for delivering family support orientated child welfare services. Those foundations included the importance attached to ensuring child protection. The research also recommended that in order for effective advances to be made there would need to be:

- a shared vocabulary of family support based on an explicit conceptual framework;
- organisational structures and support for staff reflecting family support principles;
- more done to effectively reach out and engage potential service users;
- new means of working developed, applied and rigorously evaluated;
- continued research to clarify and analyse what constitutes effective family support.

This section considers what is known today, twenty years later, about these areas as constituting the evidence base available for SiP to draw upon. It overviews the literature on family support and then, as SiP draws heavily on the 'Signs of Safety' programme, narrows the focus to that programme and the solution focused practice trend within family therapy from which it has emerged.

Defining Family Support

Family support has deep roots in the history of child welfare both with the UK and internationally (Katz and Pinkerton, 2003). Today it is more closely aligned with the aspirations of legislators, policy makers and practitioners than ever. The reform of British children's legislation led by the 1989 Children's Act gave a clear legislative mandate for family support. However, the literature and research generated in the wake of that UK legislation does not provide a large and robust evidence base in support. Rather, it demonstrates the difficulty in monitoring and evaluating the working through of the legislative mandate for family support. The research response to the challenge of 're-focusing' then and since showed how difficult it was to adequately define need and to

develop responsive services (Hellinckx, 1997; McCrystal, 2000; McTernan and Godfrey 2006; Jamal et al 2010, McLeod 2012).

A major part of the difficulty is the challenge of finding a robust conceptual framework for developing the strategic implementation of family support. This was clearly identified in a paper overviewing family support developments across the island of Ireland in 2003;

“Yet despite the clearly emerging policy commitment to family support, the experience of operational managers and practitioners suggests considerable confusion and differences of opinion over how best to implement the policy. There is as yet no widely agreed definition of family support nor is there consensus about what interventions are covered by the term and which are not.” (Pinkerton et al 2003: 309).

A decade later, a review of what research findings tell social workers about family support reports that one of the first obstacles one faces when researching family support is that there is no consensus on what the terms covers (McLeod 2012).

Accordingly it is not surprising that much of the literature and debate on Family Support focuses on definitions and principles in an effort to conceptualise Family Support as an approach to working with children and families. An important aspect of this debate has been the recognition given to thinking systemically. Support to children and parents, both informal and formal, has to be set within a wider context than just the dynamics of the nuclear family. Account has also has to be taken of extended family and friends, then neighbourhood, schools and community which in turn are effected by wider organisational networks and national policy and legislation, increasingly backed by international conventions and law. It is this multi-layered systemic interaction that generates both positive and negative change in the lives of children and parents.

Reflecting this ‘whole child/whole system perspective, in a recent contribution to clarifying the terms of the debate it has been suggested that the variety of family support found in different countries and within the same country is best understood using a matrix based on levels of intervention.

	Primary	Secondary	Tertiary
State-wide initiatives	Parenting helplines	Mediation schemes	
Community-based initiatives	Play schemes	Targeted work in children’s centres	Domestic violence programmes
Family-focused initiatives	Advice ‘drop ins’	Home Start and related home-visiting schemes	Family intervention Projects

Table 1: A Matrix of Family Support Interventions (Source: Frost and Dolan, 2012: 45)

Northern Ireland's Regional Family and Parenting Strategy 'Families Matter' includes definitions both of family and family support;

"A family consists of any child or young person under the age of 18 (21 for young people leaving care and disabled young people) and their primary caretakers. A primary caretaker can be a parent, an expectant mother or other biological relative or any person involved in bringing up the child or young person."

(Department of Health, Social Services and Public Safety, 2009: 18).

"Family support is defined as the provision of a range of supports and services to ensure that all children and young people are given the opportunity to develop to their full potential. It aims to promote their development primarily by supporting and empowering families and strengthening communities. Its focus is on early intervention, ensuring that appropriate assistance is available to families at the earliest opportunity at all levels of need." (Department of Health, Social Services and Public Safety, 2009: 18).

It is clear from that definition that the full range of interventions covered by the matrix are incorporated but that the emphasis is on family-focused initiatives aimed at early intervention as applicable at each level of need. The extent to which that view of family support reflects the general literature and research in the area can be judged by comparing it to a definition developed from a review of the international English language literature undertaken for the Irish government in 2004;

"Family support is both a style of work and a set of activities which reinforce positive informal social networks through integrated programmes. These programmes combine statutory, voluntary, community and private services and are generally provided to families in their own homes and communities. The primary focus is on early intervention aiming to promote and protect the health, well-being and rights of all children, young people and their families, paying particular attention to those who are vulnerable or at risk." (Dolan et al., 2006: 16).

In the main the Northern Ireland definition is endorsed: the need to have a range of provision, the emphasis on promoting development, not solely protecting from harm and the focus on early intervention. The evidence informed definition goes further in spelling out the rights-based aspect of provision, the need for services to be multi and inter-sectoral and the focus on those who are vulnerable or at risk.

In a later review of family support literature undertaken for the Southern Health and Social Care Trust (Houston, 2009) that definition was endorsed as still covering the main messages. However, it registered the shift away from focusing on promotion as the goal to a stress on the need to alleviate personal, social and material needs. In particular it emphasised the structural component of family support, such as anti-poverty programmes. In addition it drew attention to the value base underpinning provision;

“Services need to be offered in a way that recognises children and families as social actors who: (1) need to be treated with positive regard; (2) are entitled to a set of wide ranging personal and social rights; and (3) possess unique strengths, assets and attributes. Recognition of the child’s and family’s citizenship status, in the broadest sense possible, is therefore the axial principle in defining and shaping the contours of family support.”
(Houston, 2009).

The importance of values is a recurring theme in the literature. Whittaker (1997) argues that Family Support reflects a set of values as opposed to a clearly defined programme, with a respect for the complex task of parenting essential, and a collegiate relationship between the parent and the professional. The principles serve as an orientation to families and how best to work with them. Family Support is about recognising and responding to the needs of families, especially during a time of difficulty. The family must define their own need or problem, and the necessary support must be available when needed. To be supportive the relationship must not be experienced as threatening, alienating or demeaning. It must be offered and available on terms which make sense in the lived reality of the service user. In practice this has meant a low key, local, non-clinical, user friendly approach.

That attention to the quality of the relationship between those in receipt of family support and those providing it may not have been highlighted in the evidence informed definition was central to the set of practice principals which were drawn out in the 2006 review (Dolan et al., 2006). Much of the literature refers to the necessity of an accompanying set of practice principles to add descriptive value and to ensure that Family Support can be operationalised in a consistent yet flexible manner. The international literature offers many versions of principles or standards. The argument put forward is that although services may offer support to diverse family forms, unless they are based on, and meet specific criteria, they cannot be appropriately described as Family Support. The elements, features and characteristics of Family Support describe the efforts to distinguish between traditional human services and what are viewed as Family Support (Devaney, 2011).

To be effective family support needs to be offered within ‘pram pushing’ distance and operate on a principle of consent rather than coercion. Families must be left with a clear sense of benefiting from their involvement, with the service presented in an enticing and attractive manner. Family Support aims to enhance rather than diminish the confidence of those being helped. Of note, it will require an orientation on the part of the professional which is of respectful ally. Finally, Family Support needs to “wrap around” the particular circumstances and the age of the child and the stage of the family in its child-rearing experience (Devaney 2011).

The literature suggests that family support is as much about the way in which provision is made available to children and families as the type of provision. The following set of ten practice principles, (Dolan et al., 2006: 16-17) express the spirit of family support:

- Working in partnership with children, families, professionals and communities;
- Family Support interventions are needs-led and strive for minimum intervention required;
- Requires a clear focus on wishes, feelings, safety and well-being of children;
- Family Support reflects a strengths-based perspective which is mindful of resilience as a characteristic of many children and families' lives;
- Effective interventions are those which strengthen informal support networks;
- Family Support is accessible and flexible in respect of timing, setting, and changing needs, and can incorporate both child protection and out of home care;
- Facilitates self-referral and multi-access referral paths;
- Involves service users and front line providers in planning, delivery and evaluation on an on-going basis;
- Promotes social inclusion, addressing issues of ethnicity, disability and rural/urban communities;
- Measures of success are routinely included to facilitate evaluation based on attention to outcomes for service users, and thereby facilitate quality services based on best practice.

Child safety is clearly identified as part of a necessary child centred focus (bullet point three) but has to be set alongside the other practice principles. The linkage ensuring best practice in child protection and family support principles can also be seen in the influential Munro Review (Munro, 2011: 19). It proposes a series of practice principles to underpin a strong child protection system which clearly overlap with the ten principles of Family Support outline above. These include:

- helping families involves working *with* them and therefore the quality of the relationship between the family and professionals directly impacts on the effectiveness of help given;
- the child protection system should be child-centred, recognising children and young people as individuals with rights, including their right to participation in major decisions about themselves, in line with their evolving capacities;
- children's needs and circumstances are varied, and so the child protection system requires sufficient flexibility, with space for professional judgment to meet that variety of need;
- the complexity of the world means that uncertainty and risk are features of child protection work, and that risk management cannot eliminate harm, only reduce its occurrence;

- a learning and adaptive system is characterised by regular questioning of how the system (locally and nationally) is functioning and whether children are receiving effective help;
- good professional practice is driven by knowledge of the latest theories and research;
- the child protection system is a multi-professional, multi-agency operation, requiring all who work with children, young people and families to consider the effectiveness of their work (p.19).

Operationalising Family Support

Given the ambition of family support to be an all-embracing, strategic approach to child welfare that includes ensuring child protection and the challenge that poses to research, it is not surprising that the evidence base is weak as to 'what works' in operationalising principles such as those advocated by Dolan and his colleagues and by Munro. The evidence available on this topic is diverse but very patchy. Existing research tends to report on distinct programmes or interventions, targeting quite different sets of needs with the aim of achieving a diverse range of outcomes. This makes it difficult to compare across types of intervention and to gain clear and consistent messages from the evidence. Ideally what is required are nationally co-ordinated locality cluster studies which focus on specific geographical areas in order to identify and explore the formal services and informal social networks used by families and how they reinforce, or undermine, each other (Higgins et al., 2000). In the United States the Harlem Children's Zone is an exemplar of this approach in the area of early childhood, primary and secondary education;

"While this study leaves many questions unanswered about the effectiveness of the HCZ-provided social services, it does have very interesting implications regarding evaluative outcome measures and individual impacts on children." (Bendetti, 2012: 19).

In the UK the challenge of achieving the required degree of rigour and logistical management for this sort of research was well illustrated by the evaluation of Sure Start. From the start of that initiative an evaluation was put in place to explore how the implementation characteristics of this nationwide area based intervention influenced the impact on young children and others living in disadvantaged communities. Belsky and his colleagues (2007) note that the resulting insights hold promise for practice and applied science by illustrating how diverse sources of often qualitative data can be quantified and subject to rigorous quantitative analysis. The evidence of 'success' was mixed with some negative impacts being identified. It also became very clear just how long it took for the approach to reach full operating capacity (around three years) never mind identifiable impact. Research on Sure Start also suggested a need to find alternatives to traditional measures of fidelity and quality in order to address the core issue of realising the underlying programme philosophy.

The patch-work of evaluations that do exist tend to address either specific programmes or areas of need. Houston's review (2006) identified nine areas: primary prevention in relation to young children; secondary interventions for specific vulnerable children; therapeutic interventions for young children; therapeutic interventions for adolescents; interventions in education; primary, secondary and tertiary interventions in relation to child protection; interventions related to health outcomes; interventions in relation to race and ethnicity; and interventions for children with a disability. He drew out a number of key skills;

"First and foremost, we can point to the need for effective communication – seeing it as the bedrock of practice that aims to overturn social exclusion. Aligned to this, secondly, is the ability to listen to what children and families are actually saying about their unique narratives, hardships and successes. Thirdly, negotiation is pivotal to finding a common understanding and agreement that all the parties can broadly accept. Where possible, negotiation should proceed on an informal basis which attempts to separate the people from the problem and focus on interests and not positions. A fourth skill; that of advocacy, complements negotiation by seeking to represent and secure the interests of children and families who may be powerless in a given situation. It can take many forms including self-advocacy, citizen advocacy or practitioner advocacy. Lastly, we can point to the importance of community work skills which empower children and families to create change through collective social action and strengthen networks and collectives around common interests."

McLeod's (2012) review identified the following approaches to family support: parenting programmes, home visiting, direct interventions with children, promoting access to finance and services and reorganising services. As particular issues that had been addressed she noted: children with disabilities, families with a disabled parent, parents with learning disabilities, parents with mental health problems, parental substance misuse, young carers, child neglect, and domestic violence. Parenting programmes are the best evaluated and there is 'a wealth of evidence indicating that parenting programmes can reduce parental stress and improve children's behaviour and emotional wellbeing' (McLeod, 2012: 57). By contrast an area of need in which there is a dearth of useful research as to what works is child neglect.

From within the range of research she reviewed, McLeod draws out a number of cross-cutting themes 'not so much about what to do but how to do it' (McLeod, 2012: 67):

- comprehensive assessment taking into account the needs of each child in a family, the capacity of each parent, and the support available from wider family and community;
- an holistic approach to intervention that addresses issues relating to poverty and stigma and provides practical as well as emotional support;
- skilled and well supported staff whose work may be complemented by unqualified staff and volunteers but need to be well trained and supervised to understand and address the specific issues being faced by families, balance rights and needs and deal with the stress of the work;

- inter-professional working, not only across children's services but also between children's and adults' services;
- partnership with parents based on active listening, taking their concerns seriously and having empathy for their perspective, providing them with good information, involving them in planning, keeping them informed on the progress and outcomes of intervention and where needs be acting as advocates on their behalf;
- direct engagement with children as deserving of being listened to and respected in their own right and as a key aspect of alleviating families' overall difficulties;
- early intervention which is appropriate, timely and applied effectively.

As part of a programme of work on Families, Parents and Carers, the Centre for Excellence and Outcomes in Children and Young People's Services (C4EO) undertook a review of research to identify what works in delivering support and intervention with mothers, fathers and carers in order to improve attainment, behaviour, and emotional outcomes for children and young people aged seven to nineteen (Jamal et al., 2010). The programmes covered by that review were divided into six categories: information, advice and practical skills; emotional support; personal and social skills; family relationship building skills; opportunities to access education, training and employment; financial support and housing provision.

The key ingredients for effective practice in supporting families in community settings were identified as being: using joined-up multi-agency approaches with a dedicated co-coordinator who could focus on the complex work involved and provide a clear point of contact; having a well-trained workforce, who in particular had interpersonal and communication skills along with empathy; effective outreach including the use of the media to engage hard-to-reach people; using both practical and therapeutic interventions simultaneously, so that for example, child wellbeing outcomes linked to improved housing were reinforced by parenting skills training. The need to directly address barriers to engagement was also stressed. Fear of stigmatisation is a significant barrier to the uptake of services. Local commissioners need to consider how services can be delivered in a way that reassures users that they are not failing as parents just because they are engaging with the service, that they will be treated without demeaning judgment, and that their privacy will be maintained. Interventions are more likely to be effective when they are informed by the views of parents identified through a thorough needs assessment at the outset. This is particularly true of interventions with groups such as fathers (both resident and non-resident) and minority ethnic parents.

C4EO also carried out reviews on improving the safety, health and wellbeing of children through improving the physical and mental health of mothers, fathers and carers; and on improving children's outcomes by supporting parental and carer couple relationships and reducing conflict within families, including domestic violence. A number of themes emerged strongly across all three reviews as making for effective programmes. Firstly, partnership working. That includes both between staff in different agencies and between staff and family members. Multi-agency, flexible and coordinated services with an underpinning,

shared 'think family' ethos. This includes staff in children's services being able to recognise adults' needs and vice versa. The quality of the relationship between families can be a crucial lever in achieving change and needs to be supported by the organisational culture. Early intervention can prevent problems becoming entrenched and the practical help, advice and emotional support which both parent and children value can be provided without referral to specialist services. This requires efficient screening, assessment and referral processes, appropriate thresholds for services, accessible information about common family difficulties and where to get help and advice, offering help at times of recognised stress such as transition to parenthood and ensuring a range of help and support is available. Parents need to feel they are not being morally judged or stigmatised and be helped to overcome fears about having their children removed. Specialist services need to be visible and accessible within universal provision such as schools and health centres, out-reach techniques and befriending and peer support; staff need to be approachable, respectful and non-judgmental.

Solution Focused Practice

An important source of practice theory for informing the strengths based perspective endorsed by the material reviewed in the previous section is Solution Focused Practice (SFP). SFT is a method directed toward developing and achieving service user's own vision of solutions. It involves applying a set of techniques, such as exploring previous and existing problem solving, using particular types of questions which help specify the type and scale of change required. In this way SFT helps clarify the service user's solutions and the means of achieving them. Walsh, a leading Irish exponent of SFP and author of *The Solution Focused Helper* (2010), has reviewed the evidence base to date for this approach. She places this in the context of a developing field of practice that, since its inception in the work of the US Brief Family Therapy Centre in Milwaukee in the late 1980s, has always been concerned to evaluate its effectiveness. However the measure of effectiveness continued for many years to be client satisfaction on follow up. As a result more rigorous outcome measurement and randomised controlled studies have only really started to be done within the last decade. That said the Solution-Focused Brief Therapy Evaluation List (www.solutionsdoc.co.uk) now includes 22 randomised controlled studies, three systematic reviews and two meta-analyses, one American and one Dutch.

"Effectiveness data are available from 30 studies including more than 2,200 cases with a success rate exceeding 60 per cent and using an average of 3-5 sessions of therapy time ... Solution-focused therapy is a realistic and practical approach to many problems in mental health and elsewhere. The model is cost-efficient and training is straightforward ... It can claim to be the equal of other psychotherapies, while taking less time and resources for treatment, reducing the strain placed on the therapist and providing help for a number of groups and clients who have previously found it hard to obtain useful help form psychological therapies." (Macdonald cited in Walsh, 2010: 74).

The US meta-analysis by Kim (2006 which Walsh reviews concluded that Solution Focused Brief Therapy (SFBT) appears to be effective with internalising behaviour problems such as depression, anxiety, self-concept and self-esteem but does not appear to be effective with externalising behaviour problems such as hyperactivity, conduct problems, or aggression or family and relationship problems. Limitations of the analysis noted by Walsh include the small number of studies (22), small sample sizes and in some cases poor research design. She also notes that when Kim examined how many of the seven core components of SFBT (miracle question, scaling questions, consulting break, complimenting of client, assignment of homework tasks, looking for strengths and solutions, goal-setting, looking for exceptions) were being applied this varied from 1-7 with ten studies only using three.

The Dutch study by Stams and his colleagues (2006) was summarised as follows;

“Small to moderate effect; better than no treatment; as good as other treatments. Best results for personal behaviour change, adults, residential/group settings. Recent studies show strongest effects. Shorter than other therapies; respects client autonomy.”

(Macdonald cited in Walsh, 2010: 72).

One of the systematic reviews focused on outcomes for Solution Focused Therapy in schools, the earlier of the other two published in 2000 reviewed 15 studies and whilst encouraging did not demonstrate proof of effectiveness;

“Five studies were well-controlled and all showed positive outcomes – four found SFBT to be better than no treatment or standard institutional service; and one found SFBT to be comparable to a known intervention ... Findings from the remaining 10 studies, which we considered moderately or poorly controlled, were consistent with a hypothesis of SFBT effectiveness. We conclude that the 15 studies provide preliminary support for the efficacy of SFBT but do not permit a definitive conclusion.”

(Gingerich and Eisengart cited in Walsh, 2010: 72).

The reviewers also concluded that if the field was to move on, there was a need to develop a definitive practice model which could be set out in a manual for practice implementation. The later systematic review in 2009 analysed ten studies which they judged were sufficiently rigorous in design, used all aspects of SFBT and did not combine it with other interventions. They concluded that about half of the studies showed improvement was achieved but because of the diversity of the problems and the populations involved no definitive conclusions could be drawn as to the effectiveness of SFBT (Walsh 2010: 73).

In reviewing these findings, Walsh acknowledges that more research is required but comes to some ‘tentative conclusions’. It can be as successful in its outcomes as other brief therapies but ‘it does not provide a research basis for arguing that it is superior to other practice models if outcomes alone are the determining factor’ (Walsh 2010: 74). On the basis of her review Walsh concludes that SFBT is a ‘valid practice model to experiment with and evaluate in health and social care settings’ (Walsh, 2010: 74). It is effective to a degree,

versatile, capable of being combined with other approaches and is generalizable outside of formal therapy sessions. It provides a set of techniques and ideas about interventions, including a style of questioning that is useful to practitioners who are looking for the means to operationalize a strengths perspective in their work. Indeed one of the subtle effects from use of the model may be its influence in raising practitioners' levels of belief and hope in clients' abilities to change thereby providing motivation and expectations suited for co-operative worker/service user relationships.

At the same time Walsh warns against making exaggerated claims for SFBT's effectiveness based on unrealistic expectation of change following cognitive shift. It cannot resolve all difficulties particularly if it is only being applied in a superficial manner. More research is required into its effectiveness and in particular the specific features of the approach that work with particular clients or problems. There will always be a need to supplement it with longer term supports and interventions where appropriate. It is also important to attend to ethical issues in its application. Power relations within service user systems and service user/work systems need to be recognised and managed in a way that is sensitive to structural and gender analysis and which avoids the use of SFBT to manipulate service users into compliance with agency requirements. Walsh concludes;

“The solution-focused helper in health care and social care adopts a self-concept as ‘active change-agent’, adopts a position of hopefulness, remains articulate and engaged regarding ethics, evidence and parallel knowledge bases, and appreciates the influences of context, role and mandate on his or her work with clients/patients.” (Walsh, 2010: 76).

Signs of Safety as a Family Support Programme Based on Solution Focused Practice

A significant difficulty within the literature of social work and the broader helping professions is the lack of a literature on how to build constructive helping relationships when the professional also has a strong coercive role. The ‘Signs of Safety’ (SoS) approach to child protection casework seeks to fill this vacuum through the principles, tools and processes that assist practitioners both to undertake their statutory role and to do this collaboratively. Developed during the 1990’s in Western Australia by Andrew Turnell and Steve Edwards, SoS aims to provide a means of constructively engaging all parties involved in child protection - children, family members and professionals. It advocates a partnership approach based on a strengths perspective. It is a ‘safety-organized approach to child protection work, expanding the investigation of risk to encompass strengths and signs of safety that can be built upon to stabilize and strengthen the child’s and family’s situation’ (Government of Western Australia Department for Child Protection, 2011). It is now being used in at least 32 jurisdictions in 11 countries around the world including the UK, U.S.A., Canada, Sweden, the Netherlands, New Zealand and Japan.

SoS revolves around a risk assessment and case planning format that aims to be meaningful not only to all the professionals involved but also to parents and children. It uses a risk assessment framework (Figures 1 and 2) that focuses on four areas: danger and harm or

DANGER/HARM	Signs of Safety Assessment and Planning Form	SAFETY
<div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="width: 30%;"> <p>Safety and Context Scale</p> <div style="border: 1px solid black; width: 50px; height: 50px; margin: 10px auto; position: relative;"> <div style="position: absolute; top: 0; left: 0; width: 100%; height: 100%; background-color: #ccc;"></div> </div> </div> <div style="width: 65%;"> <div style="border: 1px solid black; padding: 5px; font-size: 0.8em; margin-bottom: 5px;"> Safety Scale: Given the danger and safety information, rate the situation on a scale of 0-10, where 0 means recurrence of similar or worse abuse/neglect is certain and 10 means that there is sufficient safety for the child to close the case. </div> <div style="border: 1px solid black; padding: 5px; font-size: 0.8em;"> Context Scale: Rate this case on a scale of 0-10, where 10 means this is not a situation where any action would be taken and 0 means this is the worst case of child abuse/neglect that the agency has seen. </div> </div> </div> <div style="margin-top: 20px;"> <p>Agency Goals What will the agency need to see occur to be willing to close this case?</p> <p>Family Goals What does the family want generally and regarding safety?</p> <p>Immediate Progress What would indicate to the agency that some small progress had been made?</p> </div>		
© 1999 Andrew Turnell and Steve Edwards		

Figure 1: The Signs of Safety Assessment and Planning Framework – Original Version
(Source: Turnell, 2012: 29)

When we think about the situation facing this family:		
What are we Worried About?	What's Working Well?	What Needs to Happen?
<p style="text-align: center; font-size: 0.8em;">On a scale of 0 to 10 where 10 means everyone knows the children are safe enough for the child protection authorities to close the case and zero means things are so bad for the children they can't live at home, where do we rate this situation? (If different judgements place different people's number on the continuum).</p> <div style="display: flex; align-items: center; justify-content: space-between; margin-top: 10px;"> 0 ← → 10 </div>		

Figure 2: The Signs of Safety Assessment and Planning Framework – Three Column Version
(Source: Turnell, 2012: 29)

worries; existing safety or strengths; agency and family goals for future safety; a safety judgment. A mapping technique is used to integrate professional knowledge alongside local family and cultural knowledge and aims to balance a rigorous exploration of danger/harm alongside indicators of strengths and safety;

“Completing the Signs of Safety assessment and planning is, in the end, simply a process of creating a map of the circumstances surrounding a vulnerable child. As with all maps, the Signs of Safety map needs always to be seen as a mechanism to arrive at a destination. That destination is rigorous, sustainable, everyday child safety in the actual home and in places in which the child lives.”

(Government of Western Australia Department for Child Protection, 2011: 3).

The mapping is done in a way that is understandable to both family members and practitioners thereby allowing them together to think through a situation of suspected or actual child maltreatment from the beginning to the end of the process of state engagement with the family. It integrates risk assessment with case planning and risk management by incorporating a future focus within the assessment. The SoS format aims to offer a simple yet rigorous assessment format that the practitioner can use to elicit, in common language, the professional and family members' views regarding concerns or dangers, existing strengths and safety and envisioned safety. A format for undertaking comprehensive risk assessment - assessing for both danger and strengths/safety – is incorporated within a one-page assessment protocol. This one page form is the only formal protocol used in the approach. The approach is designed for use from referral through to case closure and to assist professionals in any setting (community, out of home care, hospital) and at all stages of the child protection process. This format aims to encourage a deeper and balanced assessment to be made. The assessment is used to acknowledge problem behaviors within families but also to address them on the basis of identified strengths.

The approach emphasises the importance of creating and maintaining an organisational context that is conducive to it. To achieve that, a culture of 'appreciative inquiry' is promoted. It takes as its focus not the lessons of failure from the study of child deaths but detailed and critical accounting of what has worked well in practice. This mirrors the way in which Signs of Safety requires practitioners to pay close attention to what is working well within families as a resource for tackling those areas in which they have problems. This approach is what allowed the development of Signs of Safety and the same collaborative inquiry process is a feature of the approach wherever it is being used. Accordingly the model continues to develop based on what the practitioners who are using it actually do and what is working for them and the families involved. This has allowed the approach to be developed and used in increasingly higher risk cases. It has also made it very open to evaluation.

In the 1990s Edwards and Turnell undertook small follow-up studies with participants in the six month SoS development groups focused on professional identity and job satisfaction. Participants rated their sense of professional identity and job satisfaction as frontline child protection workers at the beginning and the end of the six-month project and then again in a

follow-up survey 12 months later. On a ten point scale there was almost a two point average increase in the workers' sense of professional identity and job satisfaction over the 18 month period. Carver County Minnesota surveyed its child protection staff in 2010 after two years of using SoS. Almost two thirds (64%) reported that using the approach had caused their job satisfaction to increase greatly or somewhat, with 22% saying greatly. When elaborating on the reasons for this, the most frequent responses were that: families better understood the issues and what was expected of them; the framework provided clarity and focus; it provided useful tools; encouraged more collaborative work (including with other agencies); supported better decision making; was open, transparent and honest. It is also notable that the rate of turnover of staff has remained steady at around 12% during the period since the introduction of the approach. Similar findings about the positive impact using the approach has had on staff has been noted in all the jurisdictions where the Signs of Safety approach has been applied systematically (Government of Western Australia Department for Child Protection, 2011).

The longest running and most complete implementation of the Signs of Safety within a statutory child protection system has occurred in Olmstead County Child and Family Services in Minnesota. They have been using their version of the Signs of Safety framework to organise all child protection casework since 2000 and all casework is focused around specific family-enacted safety plans. Over a 12 year period the proportion of children taken into care reduced by 50% and the number of families taken before the courts was also halved. The rate of children returning to the attention of child welfare agencies was less than 2% suggesting that the dropping care and court figures are not just about raising the threshold.

Following the lead of Olmstead County, a second Minnesota county, Carver County Community Social Services, began implementing the Signs of Safety approach in 2004. It was subject to a 'before and after' in-depth, qualitative study in which nine randomly chosen cases were used to look at the impact of the Signs of Safety approach. The study found an increase in service recipient satisfaction in most of the cases and the research helped practitioners to improve their skills, particularly in providing choice and in involving parents in safety planning. By the end 2007, termination of parental rights reduced significantly, out of home placements and children in long term care reduced, with new placements in 2008 just over half the 2005 rate. Recidivism rates also showed a downward trend (Government of Western Australia Department for Child Protection, 2011).

A more recent study focused on how parents and caregivers experienced the service, whether elements of the approach could be discerned from the parents' accounts and the extent to which worker's application of the approach led to positive experience. Overall, the findings suggest that not only are parents who received child welfare services from the five participating Minnesota counties able to recount their child welfare experiences in ways that reflect the SoS framework, but many parents generally describe these experiences positively. Based on the predominantly positive affect exhibited by parents during these interviews, it appears that the Signs of Safety model holds promise as an effective method of engaging families in assessing and planning around child safety although more research is needed to fully understand the benefits of implementing the framework relative to other child welfare practices (Skrypek et al., 2012).

In the UK, Gateshead Children's Services Authority referral and assessment (investigation) teams have been using the Signs of Safety approach in all their work since 2001. This is reported to have had a significant influence on practice and the organisational culture. It has been noted that the teams using it have a very stable workforce with far lower staff turnover than investigative teams in other equivalent authorities. Gateshead local authority consistently scores very highly on the UK's national government Ofsted audit ratings including being assessed at Grade 4 in both 2007 and 2008. In 2007 Gateshead was one of the 14 top Local Authorities and, in 2008 it was in the top three. Gateshead's standings in the national government's audit processes cannot be directly correlated to their practitioners' use of Signs of Safety but professionals in the agency say that this approach has made a significant contribution to the practice culture of the organisation (Turnell, 2012).

Two other English reviews of practice (Gardner, 2008 and Department of Children, Schools and Families, 2009 cited by the Government of Western Australia Department for Child Protection, 2011) have identified the problem that the 'recent emphasis on strengths based approaches and the positive aspects of families (for example in the Common Assessment Framework) arguably discourages workers from making professional judgments about deficits in parents' behaviour which might be endangering their children' (Department of Children, Schools and Families, 2009: 47 quoted by the Government of Western Australia Department for Child Protection, 2011). Both studies emphasise the way in which the SoS approach incorporates a strengths base alongside an exploration of danger and risk. One of the studies found that the police, social care workers (adults and children's) and Children's Guardians all thought the approach especially useful with cases of neglect. This was because:

- parents say they are clearer about what is expected of them and receive more relevant support;
- the approach is open and encourages transparent decision-making;
- the professionals had to be specific about their concerns for the child's safety;
- this encouraged better presentation of evidence;
- the degree of protective elements and of actual or apprehended risks could be set out visually on a scale, easier for all to understand than lengthy reports;
- once set out, the risks did not have to continually be revisited;
- the group could acknowledge strengths and meetings could focus on how to achieve safety

(Gardner in Government of Western Australia Department for Child Protection, 2011: 9).

One of the strengths claimed for SoS is that it has the capacity to evolve in the light of its use in practice and that it continues to do so through the application of practice-based evidence, appreciative inquiry into practitioner and recipient-defined best practice. Building a culture of appreciative inquiry and research around frontline practice is therefore an important aspect of the approach. This does not however address the limitation of small sample size and lack of control or comparison groups in the evaluations of SoS to date.

4. Safety in Partnership in the Western Trust

Safety in Partnership (SiP) is a strengths-based, safety orientated approach to work with children and families which, as outlined in the literature review, takes much of its approach from systemic theory and draws on family therapy, solution focused and brief therapy principles which involve working closely with children and families and social networks to build safety for children. Reflecting the 'whole child/whole system' perspective noted earlier as an important feature of the debate around family support, SiP has drawn on a number of key assumptions from systemic theory: the interconnectedness of systems; the importance of context as giving meaning to relationships and actions both within families and organisations; the importance of culture and beliefs underlying those meanings and culture; the importance of the fit between individual needs and the needs of the organisation; the need to attend to how voices either get heard or not heard (see Figure 3).

At the core of the approach is concern to optimise the relationship between the informal resources of a family and the formal resources of the Trust. SiP aims to build relationships between the professionals/agencies involved with the family and the family so as to clarify goals for change reflecting a shared view on problems requiring solutions. That includes helping families to understand what the Trust's concerns are as well as getting a clear understanding of family members hopes and fears.

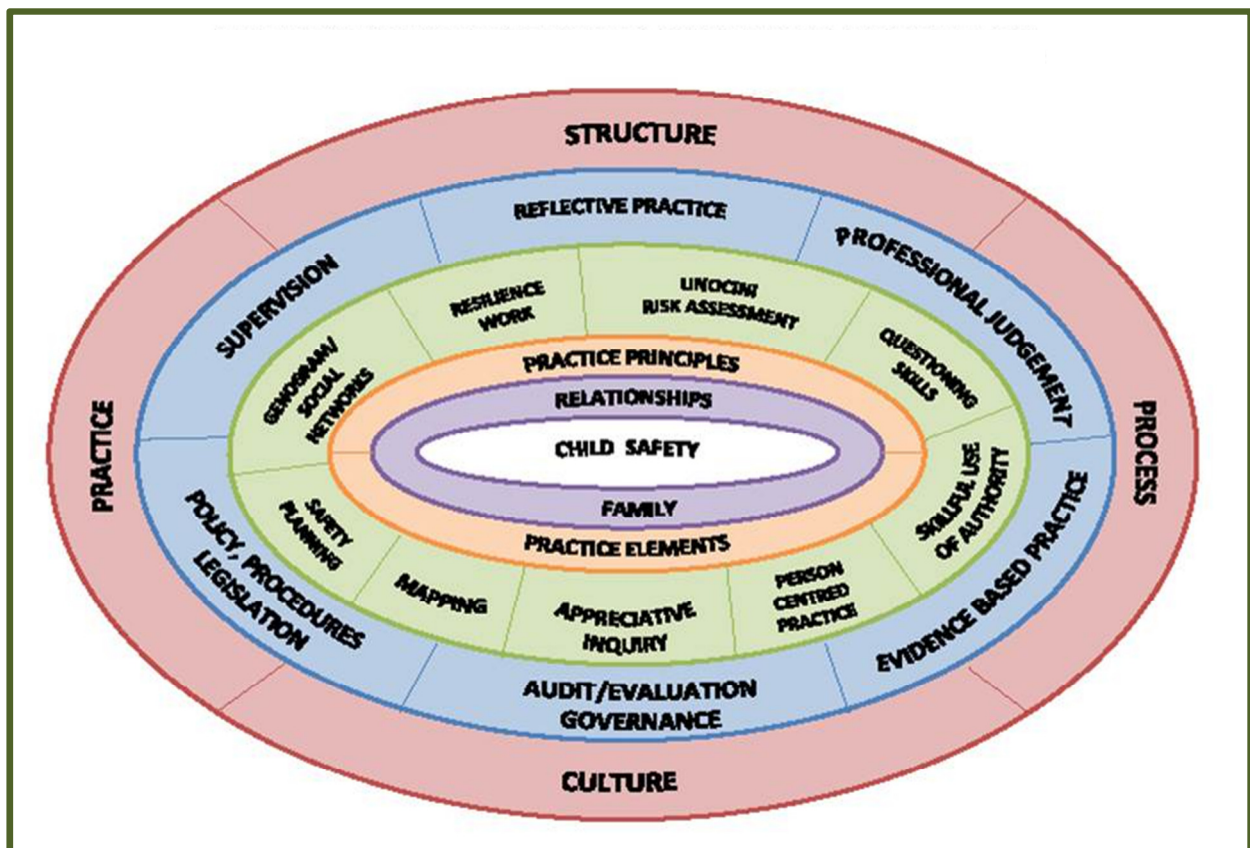


Figure 3: Safety in Partnership Systemic Approach (Source: Western Health and Social Care Trust)

The approach incorporates a number of tools, particularly a mapping framework and a set of tools for involving, and communicating with, children and young people. The Western Health and Social Care Trust (WHSCT) which is implementing the approach has not, at the time of writing, produced a detailed description of it but has outlined the aims (Figure 4) and these will be included in a Practice Manual that is currently being developed. Although the approach draws heavily on the 'Signs of Safety' approach developed in Western Australia in the 1990s (Turnell and Edwards, 1997; 1999; Turnell, 2012), the staff we have spoken to stressed that the development of SiP should not be equated with 'Signs of Safety'. The first aim of the SiP approach highlights the necessity of adhering to existing policies and procedures (Northern Ireland Area Child Protection Committees, 2005) but a number of the staff we spoke to were acutely aware of concerns that it may be used as an alternative and were keen to counter this view and emphasise how the approach complemented existing policies, procedures and processes;

"...your UNOCINI is your assessment – any other tool you use feeds into that, is incorporated into it and that's the same with this...this fits alongside and in with but the protocols, policies and procedures all take precedence."

"It replaces none of our procedures, it replaces none of the policies, none of the expectations about how we manage cases – if they meet the criteria for case conference they're taken to case conference – it doesn't replace anything that we do but it can assist in our practice."

"You know what it does, it humanises policies and procedures...we don't go outside them, we don't re-write them – we make them easier for people to understand...it's helping our staff understand we have policies and procedures and guidelines and protocols that we work in and we have to work in them...but when people understand how we apply them they're done much better and they're used in a much better way."

The majority of staff we spoke to felt that such concerns about the SiP approach were due to a lack of understanding and misconceptions about how it was being used within the Trust. This was highlighted by one member of staff who had previously worked in another Health and Social Care Trust;

"I worked within another Trust in Northern Ireland and what I had heard was that the Western Trust was using Safety in Partnership as an alternative to child protection procedures...now that I have come into the Trust I have realised that this is not the case in any shape or form."

- To embed the 12 Practice Principles to ensure that all work is carried out respectfully with children and families and that the child is central to conversations whilst adhering to existing policies and procedures
- To develop meaningful relationships with children and families and promote partnership working to promote better outcomes for them
- To ensure that the key focus is on the safety of children and young people
- To talk to families in a language they understand so that they can understand our worries and the impact of events on children and young people
- To develop meaningful plans which are individual to each child/family to promote safety
- To develop workforce skills in communicating with children and young people so that their voices are heard and included in assessment, analysis and planning
- To promote collaboration between professionals to ensure shared goals, effective communication and shared responsibility in working with children and families
- To ensure safeguarding, child wellbeing, family wellbeing and permanency for children and young people we are involved with
- To ensure that casework is evidence and research based
- To promote critical reflective practice in social work
- To draw out good practice through appreciative inquiry. This will ensure that effective casework and interventions are shared throughout the organisation
- To make better connections between different parts of the system such as risk assessment, UNOCINI, direct work with children, meetings to ensure that analysis is consistent within casework
- To promote a learning organisation

Figure 4: The Aims of Safety in Partnership (Source: Western Health and Social Care Trust)

The Safety in Partnership Approach

During discussions with staff it became clear that the SiP approach should not be conflated with the mapping framework that accompanies it. The approach is founded on twelve practice principles (summarised in Figure 5) which are taken directly from the 'Signs of Safety' approach and are a broad guide to help workers in their practice with children and families. It is these that staff emphasised during our discussions with them;

"The first thing about Safety in Partnership for me is the principles...in terms of how we work with people and what we aim to do in terms of the importance of relationships, about treating people with respect...I just don't mean how we work with families, I think it's how we work with our staff, how we work within the organisation and that's a cultural shift...for me that's the core to Safety in Partnership."

“Rather than the techniques of doing it, for me the principles behind it are the most important things...how do we work in partnership with families, how do we develop our assessments with families...and appropriate plans in order to address the needs that have been identified, ultimately to produce better outcomes. How can we encourage better collaborative working with other professionals and with families and ensure that children are central to that process.”

The aims of SiP outlined in Figure 4, and the practice principles outlined in Figure 5, can be distilled into a number of core processes that staff returned to frequently during our conversations with them:

- Building constructive working relationships with families and professionals;
- Developing a questioning approach to practice;
- Involving, and communicating with, children and young people;
- Developing a skilled workforce and learning from practice.

Building constructive working relationships with families and professionals:

The staff we spoke to were clear that the key focus of work should always be the safety of children and young people and that this should not be compromised. Good working relationships, however, were viewed as being central to ensuring this and there is, indeed, a considerable research evidence base to support the view that better outcomes for vulnerable children are achieved when constructive relationships exist (Barlow and Scott, 2010; Buckley et al., 2011; Dale, 2004; Dale et al., 2005; de Boer and Coady, 2007; Department of Health, 1995; 2001; Maiter et al., 2006). As Munro (2010) states;

“...child protection work, at its heart, involves forming relationships with children, their family members and others working to support the child.” (Munro, 2010: 16).

As the above quote makes clear, relationships includes those between professionals (collaboration) and those between professionals and families and children (partnership) and the SiP approach seeks to build constructive working relationships with families and professionals by embedding the practice principles in everyday practice;

“...the practice principles are about how we are with each other, not just with families – how we are colleagues, other agencies...and that’s what we’re trying to embed because if we can’t get it right with ourselves and the teams around us, then...”

1. Respect service recipients as people worth doing business with

Maintaining the position that the family is capable of change can create a sense of hope and possibility. Be as open-minded toward family members as possible, approaching them as potential partners in building safety.

2. Cooperate with the person, not the abuse

Workers can build a relationship with family members without condoning the abuse in any way. Listen and respond to the service recipient's story. Give the family choices and opportunities to give you input. Learn what they want. The worker must be up front and honest, particularly in the investigation. Treat service recipients as individuals.

3. Recognise that cooperation is possible even where coercion is required

Workers will almost always have to use some amount of coercion and often have to exercise statutory power to prevent situations of continuing danger, but this should not prevent them from aspiring to build a cooperative partnership with parents. Recognise that coercion and cooperation can exist simultaneously, and utilise skills that foster this.

4. Recognise that all families have signs of safety

All families have competencies and strengths. They keep their children safe, at least some, and usually most, of the time. Ensure that careful attention is given to these signs of safety.

5. Maintain a focus on safety

The focus of child protection work is always to increase safety. Maintain this orientation in thinking about the agency and the worker's role as well as the specific details and activities of the casework.

6. Learn what the service recipient wants

Acknowledge the client's concerns and desires. Use the service recipient's goals in creating a plan for action and motivating family members to change. Whenever compatible, bring client goals together with agency goals.

7. Always search for detail

Always elicit specific, detailed information, whether exploring negative or positive aspects of the situation. Solutions arise out of details, not generalisations.

8. Focus on creating small change

Think about, discuss and work toward small changes. Don't become frustrated when big goals are not immediately achieved. Focus on small, attainable goals and acknowledge when they have been achieved.

9. Don't confuse case details with judgements

Reserve judgement until as much information as possible has been gathered. Don't confuse these conclusions with the details of the case. Remember that others, particularly the family, will judge the details differently.

10. Offer choices

Avoid alienating service recipients with unnecessary coercion. Instead, offer choices about as many aspects of the casework as possible. This involves family members in the process and builds cooperation.

11. Treat the interview as a forum for change

View the interview as the intervention, and therefore recognise the interaction between the worker and the service recipients to be the key vehicle for change.

12. Treat the practice principles as aspirations, not assumptions

Continually aspire to implement the practice principles, but have the humility to recognise that even the most experienced worker will have to think and act carefully to implement them. Recognise that no one gets it right all the time in child protection work.

Figure 5: The Twelve Practice Principles (Source: Turnell and Edwards, 1999: 30-32)

Relationships with families were described as starting at the point of first contact and staff described the need to be open and honest with families, to be respectful and to use clear language so that they can understand concerns and the impact of events on children;

“...using the language of our service users, recognising that a lot of the time we were writing our reports...for a professional audience as opposed to writing them for the families who we wanted to let know what it was we were worried about.”

“...it’s about creating them relationships and saying, you know, we’re open, we’re transparent, we want to work with you...it’s getting away from all that jargon and getting down to the basics – what are we worried about? It’s very simple language...”

The aim is to develop meaningful relationships with families and promote partnership working to promote better outcomes for children. As Munro (2011: 88) notes, the formation of such relationships is ‘...fundamental to obtaining the information that helps social workers understand what problems a family has and to engaging the child and family and working *with* them to promote change.’ Rather than focusing on deficits in parenting, the SiP approach seeks to identify strengths that can be built upon in order to provide safety for children. This entails involving families in the process and offering them choices about as many aspects of the work as possible; i.e. what is ‘negotiable’ (Ferguson, 2011: 177) in order to build cooperation;

“...strike up that relationship with the family...engage meaningfully with the family...so that they have an understanding of what our concerns are, what information we might have and to get an understanding of what their views on it are and what their feelings about it are – we have them very much in the centre of it.”

A frequently cited concern about professionals attempting to build cooperative working relationships with parents and other family members is the danger that the relationship will become collusive and lose focus on the safety of children. As Ferguson (2011: 162) argues, however, taking such an approach does not ‘...mean ignoring or minimising the parenting deficits and dangers for the children that are apparent’ and this was a message that came through strongly from the staff that we spoke to;

“The core thing is about how you work with families and it’s about working in partnership...it’s not about moving away from or not working with the risk but always balancing it alongside how you work with families.”

“It’s about the importance of working with families – we want the best for families and the best for children...it’s about respecting people...sharing everything with families, cooperating with people, not the abuse...focusing on safety...but, if we feel in any way there’s a risk to a child...we’re not going to compromise a child’s safety...it’s focusing on change and building on good things in families.”

“You have to have clear bottom lines. If there’s something serious you can’t minimise it...you have to be accountable but it’s the way that you do that, still respecting...you can be very straight with someone but still have respect for them.”

32

The SiP approach seeks to take a middle ground between the two extreme positions that Barber (1991) has described as ‘casework by coercion’ and ‘casework by concession’. The first is a paternalistic, authoritarian approach to practice in which the worker’s view prevails and which leads to confrontation, conflict and the alienation of family members. The second is collusive in nature and involves the worker avoiding conflict and confrontation with the result that they overlook or minimise deficits in parenting or risks to children. The alternative to these two extremes is what Ferguson (2011: 173) identifies as ‘authoritative negotiated child protection’ which resonates with the SiP approach and does not avoid the use of authority but, rather, uses it in a respectful, constructive and skilful way. As one of the members of staff we spoke to said;

“Skilful use of authority is, I think, the greatest attribute a worker can have in child protection because then you never move into the collusion but it’s done in a respectful way that works with the power aspect of that relationship.”

Munro (2011: 23) outlines that one of the principles of a ‘good child protection system’ is that helping children and families involves working with them and, therefore, the quality of the relationship between the child and family and professionals has a direct impact on the effectiveness of any intervention. In relation to the development of these relationships, however, in her earlier report she notes that;

“...trust needs to be placed with care, and ‘respectful uncertainty’ towards families, and interest and curiosity in their narratives, needs to be part of the practice mind-set. To work with families with compassion but retain an open and questioning mind-set requires regular, challenging supervision.” (Munro, 2010: 18).

This leads directly to the second core process that can be identified from the aims of SiP and the practice principles; developing a questioning approach to practice.

Developing a questioning approach to practice:

The staff we spoke to told us that, within the SiP approach, emphasis is placed upon a questioning approach to practice. This seeks to elicit detailed information; from family members, referrers, other professionals and workers; about the details of incidents and problems, their impact on the child(ren), and the strengths and resources within the family. The rationale is that more detailed and specific information will lead to better understanding, decision-making and plans and, ultimately, to better outcomes for children and families;

“There’s a clear focus on a questioning approach...it’s looking at the questions we ask, rather than asking closed questions we like to ask a lot of open-ended questions, we like to ask a lot of strengths based questions...the detail is where you find your safety.”

“We have skilled up the workers in the duty team to ask more appropriate questions, to gather more relevant information so that the quality of the information coming through, the detail of the information coming through at that first point assists us better in being able to make the next decisions...we need to gain an understanding of how does that impact on the child and the family...and put it into context.”

This questioning approach is also used by managers in supervision in order to enable workers to review their practice and to promote critical reflective practice. This also serves to mirror for the social worker the types of questions they need to ask and the information they need to be gathering from families and other professionals;

“It’s trying to develop that culture – we ask one another those types of questions, managers will ask their social workers those questions which in turn will role model what they’re going to do in the service user’s home.”

“The questioning is key – if you ask people enough questions it begins to make them think and then their potential to go out and ask family members questions improves...”

This questioning approach to practice provides an antidote to the dangers of collusive practice, in which focus on the safety of the child(ren) is lost, discussed above. It also encourages continual reassessment of the case and the direction in which work is progressing. As one of the staff members we spoke to said;

“I believe this has helped social workers become more confident in their own practice and more confident in their own assessments. I ask them to stand over their assessments more, tell me what it is, what’s the evidence, back it up and tell me why you’re saying what you’re saying.”

The lack of reassessment of cases, and the tendency of workers not to re-examine their initial view in the light of new information, is also an issue which has been raised in previous child abuse inquiries and reviews (Brandon et al., 2010; 2012; Devaney et al; 2012). As Munro (2008) has argued;

“The single most important factor in minimising errors is to admit that you may be wrong.” (Munro, 2008: 125).

A specific technique known as ‘appreciative inquiry’ is also used within the approach which seeks to encourage reflective practice, share good practice within a team to promote learning and best practice, acknowledge what is going well and build hope, energy and confidence for working on problematic areas. Again, it involves eliciting specific details about the work and the worker’s contribution to it;

“It’s recognising the good work we do and learning from it – sharing it within the team. Also what didn’t go so well and what could be done differently.”

“It’s about drawing out good things because often we’re so problem-saturated...in terms of building morale for staff and bringing out their skills so this is a really good tool to use in team meetings and in supervision.” 34

Involving, and communicating with, children and young people:

The SiP approach places emphasis on engaging with children and young people and on developing worker skills in communicating with them so that their voices are heard and included in assessment, analysis and planning. This emphasis flows from the importance of building constructive working relationships which, as noted earlier, includes those between professionals and children and young people, and the need, outlined above, to elicit detailed information that explores the impact of problems on the child(ren);

“...giving the child a voice and then, from the child’s voice, helping the parent to understand what the impact has been on the child because that’s what we’ve found has made the difference – parents are saying they didn’t realise – they thought, for example, the child didn’t hear domestic violence, didn’t think they knew about it so it’s had a big impact...they’re saying it’s helped them understand their child.”

Two specific tools from the ‘Signs of Safety’ approach are used to communicate with children and young people (see Figures 6 and 7); the Fairy/Wizard tool, which is generally used with younger children, and the Three Houses tool, which is generally used with older children and young people. Some of the staff we spoke to, however, also spoke about using genograms and eco-maps as methods of communicating with children and the Trust have advised us that they are in the process of developing a ‘tool-kit’ of resources aimed at assisting communication with children and young people.

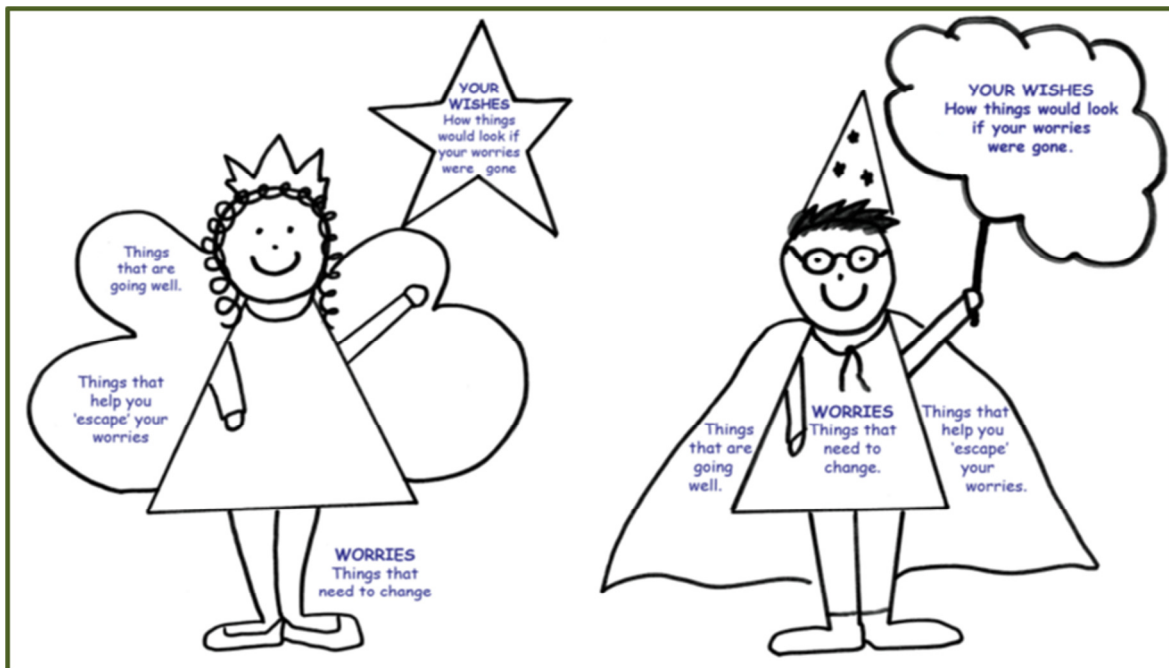


Figure 6: The Fairy/Wizard Tool (Source: Turnell, 2012: 36)

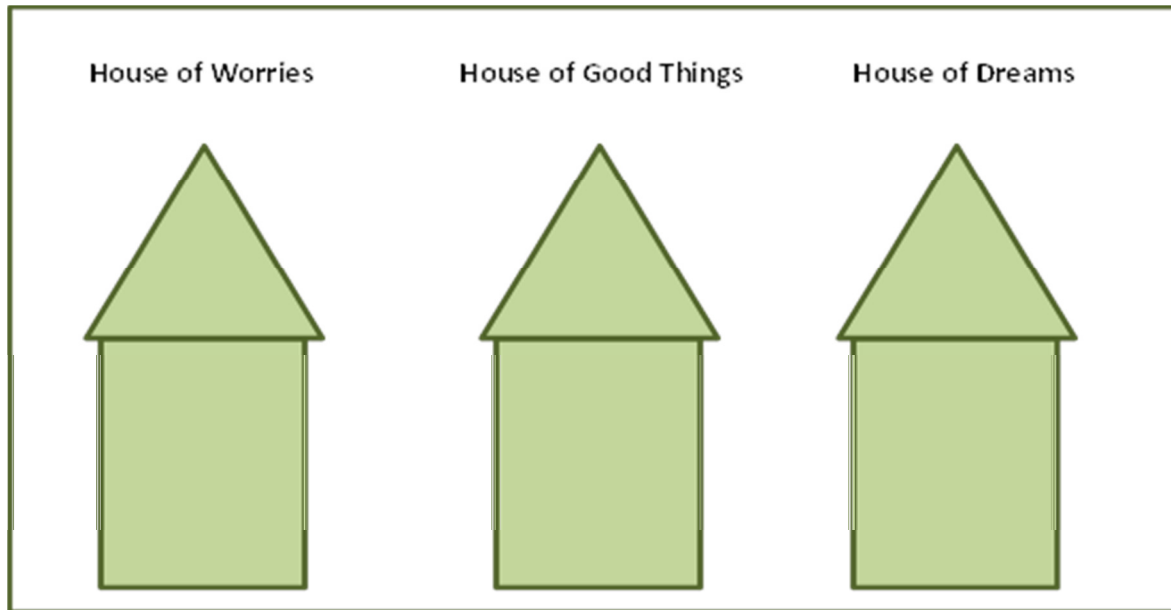


Figure 7: The Three Houses Tool (Adapted from Turnell, 2012: 32)

Training and support is provided to social work staff in using these tools in practice and there was a clear feeling among the staff that we spoke to that this was a very positive development;

“We’ve had a massive improvement in that area [communicating with children and young people] because it’s become the norm rather than anything else...this is the expectation.”

“This has really enhanced our work with children and listening to children...We have to listen to children and what they are saying and these tools can be really powerful.”

“A big part of Safety in Partnership is doing work with children...it’s amazing when social workers sit down and do these with children what I’m getting back to inform assessments even further...”

This emphasis on involving, and communicating with, children and young people is clearly consistent with Article 12 of the United Nations Convention on the Rights of the Child, which outlines that ‘States parties shall assure to the child who is capable of forming his or her own views, the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with age and maturity of the child.’ It is also consistent with Article 3 of the Children (Northern Ireland) Order 1995 which requires that due regard is given to the ‘ascertainable wishes and feelings’ of children, considered in light of their age and understanding). As Munro (2011) notes, however;

“Children and young people are a key source of information about their lives and the impact any problems are having on them in the specific culture and values of their family. It is therefore puzzling that the evidence shows that children are not being adequately included in child protection work.” (Munro, 2011: 25).

A frequent finding from inquiries and reviews into child deaths has been that the child was not seen frequently enough by the professionals involved or was not asked about their views, wishes or feelings (see for example Ofsted, 2010; Brandon et. al., 2012; Devaney et al., 2012). As Turnell (2012: 31-32) argues, one possible reason for this is that workers 'are rarely provided with straight forward tools and practical guidance that equips them to involve children.'

The tools used to communicate with children and young people can also be adapted for use with adults who find it difficult to understand information provided in written form;

"We have also used these tools, on occasions, with adults who have low ability or learning difficulties...so even by using the Three Houses to demonstrate what we might be worried about...it helps them get a very clear understanding of what our worries are and what it is we're concerned about but it equally helps us understand what they're worried about - so it's using the tools to be able to communicate more effectively with adults who maybe have learning difficulties and that has been very effective..."

Developing a skilled workforce and learning from practice:

In order to develop a skilled workforce, the SiP approach is underpinned by a comprehensive training programme and Figure 8, for example, presents the training calendar for 2012-2013. Assessed Year in Employment (AYE) and other new staff undertake a one-day course called 'Introduction to Safety in Partnership'. This provides an overview of the SiP approach including the practice principles, the mapping framework and the creation of safety plans for children and young people (see following section). 'Three Steps Training' involves three one-day courses which take social workers through the three steps associated with the mapping framework so that they fully understand this process. 'Communicating with Children and Young People' is a one-day course which examines how to involve children and young people and communicate with them. The training explores the use of genograms, the 'Three Houses' and 'Fairy/Wizard' tools and other ways of engaging children and young people. 'Questioning Skills Training' involves three one-day sessions examining the need to elicit detailed information from family members and other professionals and the types of questions that are helpful in doing this. 'Stakeholders' Awareness Training' is a half-day course providing information about the SiP approach to other agencies and professionals.

'Practice Leaders' Training' is a six-day training programme run in three two-day blocks which is aimed at Service Managers, Social Work Managers and Senior Practitioners given the leadership roles they have within the organisation. The training includes the need to embed the practice principles in everyday practice, skills such as completing genograms, questioning skills and appreciative inquiry, the mapping framework and the development of robust safety plans. The main role of Practice Leaders is to facilitate the mapping of cases using the mapping framework discussed below. It is only these staff, who are Band 7 and above, who, having undergone this training programme, should facilitate a mapping process due to the level of knowledge, skill and values required.

1. **THREE STEPS TRAINING**
(Mapping, Risk Statements and Safety Planning) for Social Work staff in Gateway, FIS, LAC and 16+ services – June 2012 (1 day x3).
 - 13/06/2012
 - 20/06/2012
 - 27/06/2012
2. **THREE STEPS TRAINING**
(Mapping, Risk Statements and Safety Planning) for other Social Work staff will take place in September.
 - 17/09/2012
 - 19/09/2012
3. **PRACTICE LEADERS TRAINING – 6 days training – Sept-Oct 2012.**
 - 12th and 13th September
 - 26th and 27th September
 - 8th and 9th October
4. **QUESTIONING SKILLS TRAINING- 3 x1 day training events beginning October 2012.**
 - 26/10/2012
 - 19/11/2012
 - 03/12/2012
5. **COMMUNICATING WITH CHILDREN AND YOUNG PEOPLE- September- November 2012.**
 - 21/09/2012
 - 28/09/2012
 - 05/11/2012
6. **STAKEHOLDERS' AWARENESS TRAINING – November 2012.**
 - 23/11/2012 9.30 – 12 noon
 - 23/11/2012 2pm – 4.30 p.m.
7. **PRACTICE LEADERS' TRAINING - 6 days training - Jan- Feb 2013.**
 - 17th, 18th, 30th, 31st January
 - 21st and 22nd February

Figure 8: Safety in Partnership Training Programme 2012-2013 (Source: Western Health and Social Care Trust)

Following training, Practice Leaders are expected to assist in leading the SiP approach within their office and to act as role models and to provide support, including through supervision, and resources to enable social work staff to implement the approach and develop their practice skills. There is an emphasis on sharing and learning from good practice which is formalised through the 'Practice Leaders' Forum' and the 'Quality Assurance Group'. The Practice Leaders' Forum meets on a monthly basis and keeps Practice Leaders up to date with developments, provides good practice examples, explores difficulties and draws out learning from day-to-day practice which is then fed back to social work staff in each of the

offices. The 'Quality Assurance Group' also meets on a monthly basis and, in addition to planning, evaluating and reviewing the training programme, it reviews pieces of work undertaken by individual staff including case mappings, safety plans and pieces of work completed with children and young people. General messages and learning points from this review of work are distributed to all staff but individual feedback on specific pieces of work is also given to practitioners and their line manager in order to ensure a constant focus on quality and the development of practice.

The SiP approach, as outlined above, appears to be highly consistent with a number of the principles outlined in paragraph 1.13 of *Co-operating to Safeguard Children* (Department of Health, Social Services and Public Safety, 2003) which emphasise that;

- The child's welfare must always be paramount;
- A proper balance must be struck between protecting children and respecting the rights and needs of parents and families but, where there is a conflict, the child's interests are paramount;
- Children have a right to be heard, to be listened to and to be taken seriously and, taking account of their age and understanding, they should be consulted and involved in all matters and decisions which may affect their lives;
- Parents/carers have a right to respect and should be consulted and involved in matters which concern their families.

The Mapping Framework

As part of the SiP approach a mapping framework is used and this is presented in Figure 9. Although based on the 'Signs of Safety' assessment and planning framework (see Figures 1 and 2) this is in fact taken from a development of this framework utilised in Olmsted County, Minnesota (Lohrbach and Sawyer, 2004; 2005) which is more structured and detailed and aims to help workers think through the issues in the case and communicate these clearly to families. As outlined earlier, the mapping process is facilitated by staff at Band 7 or above who have completed a six-day training programme, i.e. Practice Leaders, and six 'practice elements' (Figure 10), again taken directly from the 'Signs of Safety' approach, are provided to aid staff who are facilitating the mapping of cases.

The mapping framework proceeds via three inter-linked steps (mapping, risk statements, and safety plan);

"There's your mapping to get to very clear risk statements to get to a very clear plan because, if you're not clear in your risk statements you can't do plans..."

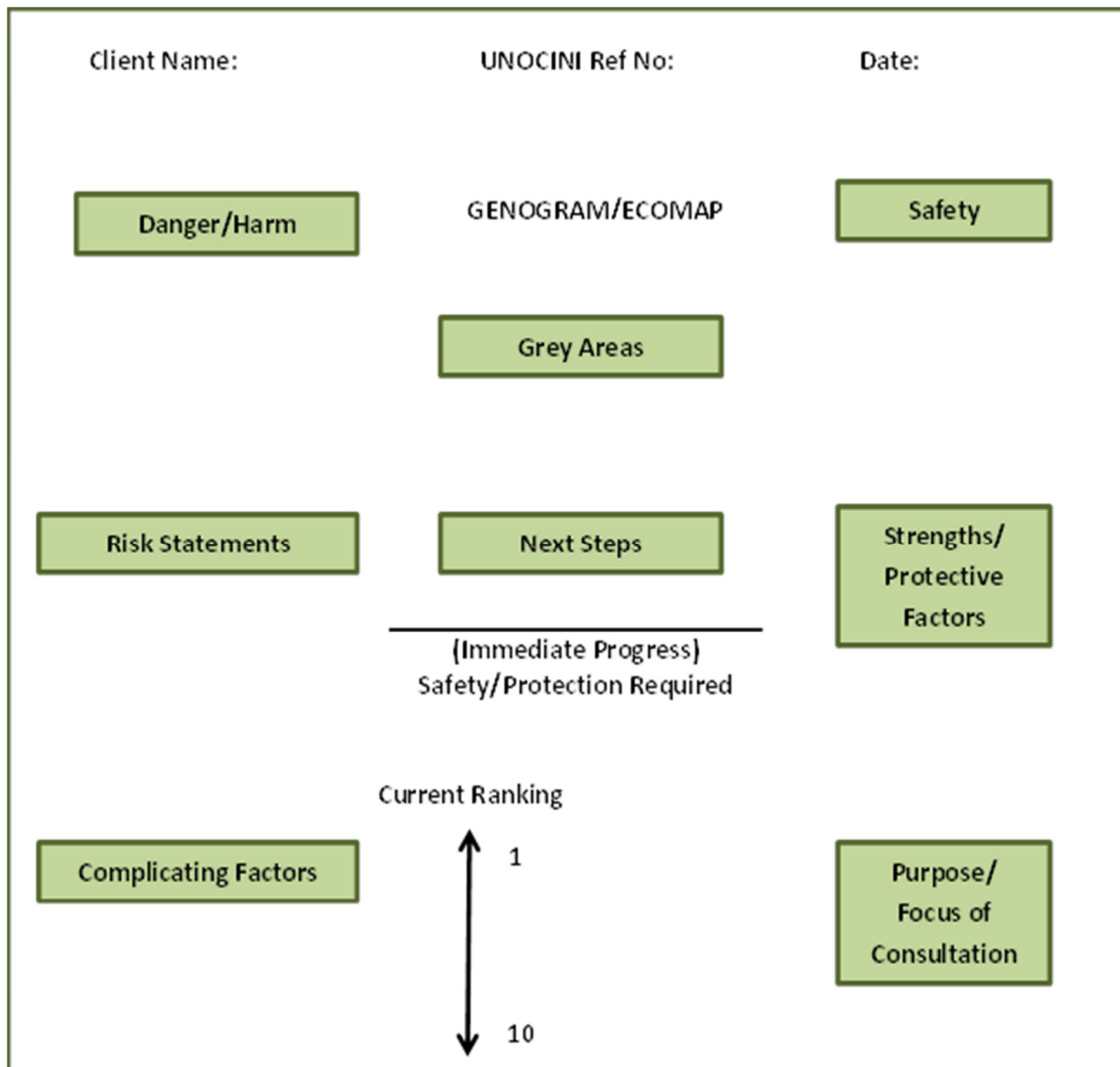


Figure 9: The Mapping Framework (Adapted from Lohrbach and Sawyer, 2005: 51)

Mapping:

Information about the case is presented and recorded in a number of categories in the framework to enable detailed discussion of the case. These categories are not mutually exclusive as discussion of one area may reveal information relevant to another area. The first area discussed is the **purpose/ focus of consultation** which refers to the type of meeting being held (case conference, core group, case planning, supervision session, etc.) and the decisions that need to be made/can be made in that forum;

“If you use your map, say in supervision, then you can only use it for next steps that could come out of a supervision process. If you use it in a core group, then you think about what authority does a core group have with regards to decision-making in a case and only use it in that context. If you were to have a professional meeting, say like a peer group supervision, then you can only make decisions in relation to professional roles and responsibilities but not relating to the family.”

1. Understand the position of each family member

Seek to identify and understand the values, beliefs and meanings family members perceive in their stories. This assists the worker to respond to the uniqueness of each case and to move toward plans the family will enact.

2. Find exceptions to the maltreatment

Search for exceptions to problems. This creates hope for workers and families by proving that the problem does not always exist. Exceptions may also indicate solutions that have worked in the past. Where no exception exists, the worker may be alerted to a more serious problem.

3. Discover family strengths and resources

Identify and highlight positive aspects of the family. This prevents the problems from overwhelming and discouraging everyone involved.

4. Focus on goals

Elicit the family's goals to improve the safety of the child and their life in general. Compare these with the agency's own goals. Use the family's ideas wherever possible. Where the family is to suggest any constructive goals, danger to the child is probably increased.

5. Scale safety and progress

Identify the family members' sense of safety and progress throughout the case. This allows clear comparisons with workers' judgements.

6. Assess willingness, confidence and capacity

Determine the family's willingness and ability to carry out plans before trying to implement them.

Figure 10: The Six Practice Elements (Source: Turnell and Edwards, 1999: 51)

The next area discussed is a **genogram and/or eco-map** which is used to help understand who's who in the family and to explore the nature of family relationships. If certain family members are not present then this discussion helps bring them 'into' the process and, likewise, if only professionals are involved in the discussion, it helps bring the family 'into' the process. The process then moves on to a discussion of **danger/harm** which refers to the reasons why Social Services are involved with the family, the things that people are worried about, and the things people are saying have happened, or might happen, to the child(ren) that make them worried. This is followed by a discussion of **strengths/protective factors**, i.e. the assets, resources and capacities within the family or individuals within the family and which may balance out some of the things people are worried about (danger/harm).

Complicating factors refer to conditions or behaviours that contribute to greater difficulty for the family. Sometimes these are about the family or things happening in the family and sometimes they are about professionals and the services provided (e.g. poor relationship with social worker). **Grey areas** is a means of capturing things that are not yet known or are unclear (e.g. outstanding reports, information from another agency/department that has not been accessed, the views of a family member who is not present, etc.). Discussion of **safety** involves the identification of existing strengths/protective factors which have been demonstrated over time and address some of the identified danger/harm. It is important to note that strengths and protective factors do not equate to safety as safety can only be identified when strengths/protective factors that address identified danger/harm have been demonstrated over time and this can be verified by professionals. As one member of staff from the Gateway Service said;

“Sometimes we don’t have safety. That happens very often with us in a Gateway team because we haven’t identified any safety so all we have is danger/harm and risk statements...if we are able to develop a safety plan it’s only a very interim, short-term safety plan and it needs to be picked up [by the Family Intervention Service] and that process needs to start again...a lot of the times we don’t have safety identified or we’re not in a position to say there is safety because we don’t know enough about the family or we haven’t seen it.”

Current ranking refers to scaling on a scale of 1-10 and can be used throughout the mapping process. This may be in relation to a decision that needs to be made (e.g. is the case ready for closure) or an issue discussed at the meeting (e.g. the degree of seriousness in relation to danger/harm) and allows for differences of opinion, for example between professionals and family members, to be acknowledged and explored. The development of **risk statements** is key to the process of safety planning and these are discussed separately below. **Next steps** are developed from danger/harm, complicating factors and grey areas and outline actions that need to be taken including those needed in order to ensure immediate protection of the child(ren). Depending on the risk statements developed, this may be that the child needs to be removed, needs to be on the Child Protection Register, or that Care Orders need to be applied for.

Risk Statements:

Once the case mapping is completed risk statements are created based on the risk assessments which have been completed. Risk statements are clear, specific and detailed statements, written in understandable language, regarding risk and should describe what professionals are worried will happen to the child(ren) in the care of parents/carers if nothing changes. Risk statements should cover:

- | | |
|--------|---|
| WHO? | <ul style="list-style-type: none"> • Who is worried? • who is at risk? • who is the risk from? |
| WHAT? | <ul style="list-style-type: none"> • what is the risk? |
| WHERE? | <ul style="list-style-type: none"> • where does the risk occur? Specific places? |
| WHEN? | <ul style="list-style-type: none"> • When does the risk occur? Specific to times? |
| HOW? | <ul style="list-style-type: none"> • How would risk be likely to happen? |

The rationale is that, if risk statements are clear and detailed, then the safety plan which follows on from these will also be detailed and specific. Some examples of risk statements, taken from SiP training materials, are presented below;

“Social Services and the Guardian ad Litem are worried that [child] could be physically or emotionally hurt when [mother] and [father] get into arguments and fights and they become so wrapped up in the argument that they forget to pay attention to [child].

“Social Services and the Guardian ad Litem are worried that [child’s] illness may get worse when [mother] does not follow medical recommendations.”

“Social services and [grandmother] are worried it won’t be safe for [child] to live with mummy and daddy again because mummy and daddy might get into fights again like the one last year that put mummy in hospital with broken ribs and a fractured cheek. If this happens again Social Services and [grandmother] are worried [child] will become so terrified he won’t eat or sleep and won’t be able to go to school and will be crying all the time like he was when he went to stay with [grandmother] after that big fight last year.”

These risk statements inform ‘bottom lines’, i.e. clear statements about what is the absolute minimum requirement to protect the child(ren) from harm and the actions that must be taken to address the dangers identified and refer to what is ‘not negotiable’ (Ferguson, 2011: 176). These ‘bottom lines’ should be made clear to the family as should the action that will be taken if the line is crossed.

Safety Plans:

A safety plan is developed with the family and this involves discussion with them in order to develop a plan that describes specific behaviours and actions that address the risk statements and avoid ‘bottom lines’ being breached. The plan has to be very specific (who, what, where, when and how) and also indicate again what is not acceptable (the ‘bottom line’) and what action will be taken if the plan is not adhered to.

The safety plan must be written in clear, straightforward language that is understandable to the youngest children so that it can be presented to them and they can be involved in its subsequent implementation and refinement. It must be endorsed by the professionals involved in the case and the social worker must regularly monitor and follow-up with the children and all the adults involved in implementing the safety plan to verify that it is being implemented and is working. The safety plan needs to be tested out and monitored over time and reviewed and amended as necessary;

“We have bottom lines with any safety plan...we might say that mum can never be in a room on her own with the baby. The family need to tell you how they will make sure that happens, to talk through the challenges and then you get a safety plan that contains enough detail for you to be convinced...then you need to think about how you monitor it...your review of that safety plan then is key because some safety plans will need reviewed daily at the start.”

Use of the Mapping Framework

A recent systematic review of models of analysing significant harm (Barlow et al., 2012) has raised reservations regarding the efficacy of the 'Signs of Safety' framework in risk assessment practice. These reservations have been highlighted to the WHSCT via correspondence from the Deputy Secretary (Social Services Policy Group), Department of Health, Social Services and Public Safety and the Director of Social Care and Children, Health and Social Care Board with the Trust being asked to provide assurances that SiP is not being used as an alternative to child protection processes.

In relation to this, the staff we had discussions with made a number of points. Firstly, as already stated, the WHSCT are not using the 'Signs of Safety' framework but a more structured and detailed development of it aimed at helping workers think through the issues in the case, make decisions about what needs to happen next, and communicate these clearly to families;

"The tool that we use for mapping is much more structured because it looks at the danger/harm or the presenting problem and looks at the complicating factors, risk statements, safety, strengths...it has a much better layout for what we do in our job...the one we use is a very clear, structured decision-making tool."

Secondly, that the mapping framework is not used in every case and is not being used as a risk assessment tool. The framework is used to enable detailed discussion of the case and the concerns involved, decision-making regarding action that needs to be taken, and the communication of these to professionals and family members. Risk assessment, however, occurs before the mapping process and informs the development of risk statements and subsequent safety plans;

"It isn't a risk assessment tool because we should be identifying the risks before we get in there, so we need to know the risks..."

"In terms of risk assessments we're not doing anything really different from the rest of Northern Ireland – the framework is just a way of analysing, thinking through things, finding patterns, finding strengths in families...getting a real understanding of cases."

"It's a framework for thinking through things, not a risk assessment model...we're saying to people, still use your UNOCINI and your risk assessment tools and everything needs to feed into each other."

Finally, that the framework is not being used as an alternative to child protection processes but as a complement to them. This message came through very clearly in training materials and internal Trust correspondence that we received copies of and the staff we spoke to were also keen to emphasise this;

“Us bringing in Safety in Partnership – it wasn’t about moving away from anything, it was about connecting everything...We are very keen to make sure that it is all connected, that it all sits within the processes and the policies and procedures and that our staff and our managers understand how it connects.”

“I mean your bottom line is your bottom line. You’re still going to case conference if you have to but, as I say, it doesn’t replace any of your policies and procedures, nothing like that.”

“It can help in our decision-making, it can help with clarity of thinking, it can help with the detail of where we might go next, it can help with the focus us on the plans that we come out with, it can help us engage better with families, it can help us get better and more meaningful information from children but it absolutely does not replace anything that we do in terms of policies and procedures.”

“There’s no such thing as a ‘mapping meeting’ – you have to bring that in to your core groups or into your case planning meetings. It’s not a separate function because we still have to go, obviously, by our statutory obligations which is your core groups, your case planning meetings or whatever it is. It needs to go alongside that, it’s not a new meeting – it’s incorporated in.”

In our discussions with staff it became clear that mapping is not necessarily a one-off process; the same case can be mapped several times for different purposes and the mapping can take place in different contexts such as case conferences, core group meetings, case planning meetings, family meetings, supervision, etc.

Firstly, in relation to child protection processes, the framework can be used as outlined above to help develop a safety plan to address the identified risks to a child or young person. Within the Gateway Service, for example, a case may be mapped with the social work manager, social worker, family members and key professionals prior to an initial child protection case conference in order to formulate an interim safety plan to address immediate protection needs. During this process, concerns can be communicated to family members in an understandable way and professionals are enabled to think through the issues involved in the case in a critical way. Barlow et al. (2012) note that the strengths of the ‘Signs of Safety’ framework and similar frameworks, such as the one used in SiP, are;

“...that they can be used to (a) map the evidence as part of the process of ‘making sense’ of it; and (b) as a visual tool for use as part of working in partnership with children and families, to help them to understand their strengths alongside problem areas”
(Barlow et al., 2012: 73).

Indeed a number of the staff we spoke to highlighted that use of the approach had a positive impact on families in terms of enabling them to understand Social Services concerns and in developing constructive working relationships;

“I’ve had families saying, see with it being written up in black and white, it has actually hit them more powerfully than actually hearing it.”

“You’re bringing families with you...They see the risks up there in black and white and probably, if anything, it reinforces the risks even more to the family.”

“Families also like it – I think they don’t feel like they’re being dictated to. Instead of us pointing the finger with a child protection plan or a family support plan or whatever it is, they’re involved in the process and aren’t just being told what to do. They are actually being helped and encouraged to provide safety for their own family but we’re obviously ensuring that that happens and helping them along with it.”

Mapping may also take place at an initial case conference in order to develop an initial safety plan, which will form part of the child protection plan produced at the case conference, and to determine ‘bottom lines’ and risk statements which will guide the formulation of a more detailed safety plan afterwards with the family. This work may be delegated to the social worker to complete, in which case it will be brought to a core group meeting for approval, or it may be delegated to the core group itself as a piece of work to be completed by them. As stated, the safety plan developed will be approved by the core group and will be formally reviewed at the review child protection case conference. Mapping of cases may also take place prior to a review case conference to review progress made in the case and inform recommendations made to the case conference;

“I might use mapping in a core group meeting prior to a case conference maybe to look at, are we at the point of de-registration here? What are we worried about? Could we work this case under family support?”

Secondly, the mapping framework can be used in individual supervision to encourage reflection on the work being undertaken, to quality assure the work and to give direction in terms of work that needs to be done, information that needs to be gathered, etc. and in group supervision and team meetings to enable reflection and the sharing of learning from practice;

“Sometimes social workers go out and do an initial assessment and may come back and go, you know, I’m not happy, I’m not sure – so I say, right, let’s map it and see what we’ve got here...it gives the social worker focus and direction, they know, right – this is what I need to do, next steps.”

“...the mapping can be used as a tool in supervision as well to look at practice...we don’t just do it one-to-one, it’s peer and it’s group supervision that we would use it in and you do see a difference in social workers when you get them to focus on what’s working well and what’s not working well.”

“It could at times expose vulnerable social workers, you know, where practice is a worry...and that’s not a bad thing for us because it’s good governance...when you’re mapping a case you see very clearly what’s happening and what’s not happening – so your next steps could normally be full of ‘I need you to...’ and then, when you’re mapping it again you’re making sure it’s been done so there’s a really strong governance element...”

Thirdly, a number of staff also discussed the specific value of the framework in terms of helping to re-evaluate cases in which progress did not appear to be occurring or to challenge their perceptions of the case and encourage them to reflect on the direction of work being undertaken;

“...it’s good in a case maybe where children have been on the register for a long period of time, you know, and almost a case gets stuck – it’s very good then to put it up there in black and white...it’s a good way of moving a case maybe one way or the other...That’s where I find it most useful, when I think I need to look at this again – keeping the work purposeful.”

“We don’t map every case but with the cases that, you know, those cases where were you think ‘I don’t know what to do with this, this case has been in this office for three years and I’ve tried absolutely everything’ it can be really helpful.”

Fourthly, within the Gateway Service, weekly RED (Review, Evaluate and Direct) meetings take place. These are another element taken from Olmstead County, Minnesota (see Lohrbach and Sawyer, 2005) and are attended by Social Services and other key stakeholders, such as the family support hub coordinators and representatives from other statutory and community and voluntary organisations. At the meetings cases on the borderline between Levels 2 and 3 of the Hardiker model (Hardiker et al., 1991) are mapped by the social work manager in order to evaluate if statutory intervention is necessary or if the child and family’s needs can be met at Level 2 of the Hardiker model, i.e. managed within the community.

The staff we spoke to highlighted a number of perceived benefits arising from this process in that it ensures that:

- statutory services focus on those cases at higher risk;
 - resources invested in Level 2 services are used effectively;
 - early intervention is available for families within local communities;
 - there is less stigma for those families who can access local services;
 - services are working together collaboratively to identify the needs of children and families.
-

Finally, the Trust is currently piloting the mapping of cases at the point of transfer from Gateway to the Family Intervention Service. This began in mid-September 2012 in the Enniskillen office where the services are co-located and will run for three months and then be evaluated. The intention is that the case will be mapped between the two services in order to agree an interim plan prior to the case plan being agreed at the initial case planning meeting and that there will be a joint hand-over visit to the family by the Gateway and Family Intervention Service social workers;

“We’re trying now, at the point of transfer, to map the case together...and that’s a good way of our social worker in Family Intervention getting to know the case.”

Governance

A number of systems are in place to support the implementation of the SiP approach within the Western HSC Trust and their key roles and responsibilities are summarised below:

QUALITY IMPROVEMENT BOARD (Chaired by Director of Social Work).

Meets bi-monthly.

- Overall accountability for the success of Safety in Partnership
- Provides overall direction and guidance to the Project
- Ensures the Project meets the agreed standards of time, quality, cost and evaluation
- Ensures the Project remains viable
- Takes key decisions

PROJECT TEAM (Chaired by Assistant Director – Gateway and Family Intervention Service).

Meets monthly - First met on 27th June 2011.

- Oversee and plan implementation of the Project deliverables
- Oversee the Training Programme
- Discuss any issues of concern in preparation for the Project Board
- Ensures governance issues are addressed
- Maintains the momentum of the Project

QUALITY ASSURANCE GROUP (Chaired by Assistant Director – Workforce Development and Governance).

Meets monthly – First met on 6th July 2011.

- Plan and deliver training programme
- Review and evaluate training provided
- Quality assure practice tools
- Advise Project Team of best practice and governance issues

STAKEHOLDER GROUP (Chaired by Assistant Director – Gateway and Family Intervention Service).

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Meets quarterly – First met on 15th September 2011.

- Informed about the Project Plan and updated on progress
- Feedback on implementation of Safety in Partnership from stakeholders' perspectives
- To ensure good communication and understanding when issues arise
- To highlight exemplars of good practice
- To discuss any governance issues and appropriate action steps required

PRACTICE LEADERS' FORUM (Facilitated by SiP Implementation Officer).

Meets monthly – First met on 20th April 2011.

- To embed Practice Principles in day to day work
 - Promoting collaborative practice within the social work teams
 - Having a learning, safe environment to embed this way of working
 - Strengthening Practice Leader's own skills/style in facilitating.
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5. The Development of Safety in Partnership in the Western Trust

The development of the SiP approach in the WHSCT can be traced back to the 'New Beginnings' strategy implemented in the legacy Foyle Health and Social Services Trust (Foyle Trust) from February 2003 onwards. The background to this strategy was the implementation of the Children (NI) Order in November 1996 which brought with it increased expectations in terms of professional practice without increased resources. From the implementation of the Order in November 1996 up until the end of the 1990s, Foyle Trust experienced severe difficulties in meeting its statutory obligations and increasing unrest amongst social work staff;

"It was a build-up of staff feeling overwhelmed with the work that they were required to do and a huge emphasis from the Children Order on family support and a frustration from staff on the ground who didn't feel able to do anything about that."

This situation eventually led to industrial action being taken by the Trust's social work staff between 1999 and 2000. In response, the Western Health and Social Services Board commissioned a management consultancy firm to undertake a review of the extent to which Foyle Trust was meeting its full range of delegated statutory functions to desired standards of quality (Evans and Ford, 2001). The review report made 87 recommendations and called for a clear sense of direction regarding the allocation of resources according to need within priority groups, particularly the prioritisation of existing resources to looked after children, children in need of protection from significant harm and children with disabilities.

Foyle Trust established a comprehensive project to address the review's recommendations and, from this, the 'New Beginnings' strategy emerged. Deirdre Mahon, then an assistant Principal Social Worker in the Waterside office in Derry/Londonderry was seconded as project lead in January 2001 and remained in that post until 2005. The Trust commissioned an evaluation from the Child and Family Research and Policy Unit, NUI Galway in late 2004 which reported in June 2006 (Dolan et al., 2006). The evaluation report describes 'New Beginnings' as a;

"...fundamental and comprehensive programme of structural, strategic and cultural change in Foyle Trust's services for children and families...the programme aims to meet need more effectively by committing to identify and work with priority need and to do so according to a Family Support orientation." (Dolan et al., 2006: 5).

During this period the inspection of child protection services was underway with the reports for Foyle Trust being published in September 2004 (fieldwork services) and July 2006 (residential and fieldwork interface) making a total of 149 recommendations (Social Services Inspectorate 2004; 2006a). The report inspection of child protection services in Sperrin Lakeland Trust, soon to be amalgamated with Foyle Trust in the new WHSCT, was published in July 2006 and made 185 recommendations (Social Services Inspectorate, 2006b).

The WHSCT was established on 1st April 2007 and brought together the delivery of health and social care which had previously been provided by three separate Trusts (Foyle and Sperrin Lakeland community Trusts and the Altnagelvin Hospitals Trust). The staff we spoke to indicated that this was a very unsettling time and that some of the momentum that had been generated by 'New Beginnings' in Foyle Trust had been lost;

"It was at that time that things kind of went all fragmented again...it was like starting over again..."

The legacy Sperrin Lakeland Trust had also established a 'New Beginnings' project at the request of the western Health and Social Services Board although, from what we have been told, this focused on a reorganisation of child care services without the cultural change that had underpinned the strategy in the legacy Foyle Trust. Staff told us that the 'eye was taken off the ball' in relation to 'New Beginnings' at this stage due to a number of other developments that required attention. These included the implementation of recommendations from the child protection inspections in the legacy Foyle and Sperrin Lakeland Trusts, which the WHSCT took forward through a newly established 'Improving Quality Together Project Board' and the work of the regional Reform Implementation Team which was established to take forward the implementation of the recommendations of the child protection inspection and the associated developments required to improve services to children. Staff morale in the legacy Sperrin Lakeland Trust was also reported to be very low at that time;

"For us it was like going back to our days of strike, you know, that kind of feeling where staff were very overwhelmed, social workers leaving – nobody staying for very long periods of time – high turnover of staff...it was a very unsettling period."

In November 2007, less than eight months after its formation, the WHSCT was rocked by the Omagh tragedy in which Mr Arthur McElhill, Ms Lorraine McGovern and their five children died in a house fire. The Department of Health, Social Services and Public Safety commissioned an independent review of agency involvement with the family on 10th January 2008 and the review team, chaired by Henry Toner QC, reported in June 2008 (Department of Health, Social Services and Public Safety, 2008) making 63 recommendations. The report was critical of social work practice in the Omagh sector of the WHSCT and noted that;

"The events...show that competent professional practice was not followed in a number of instances particularly in responding to concerns raised and referrals made, conducting assessments, risk assessments and working with other disciplines and agencies. The professional practices of the relevant social workers were not adequately monitored, supported or challenged by senior staff..."

(Department of Health, Social Services and Public Safety, 2008: 16).

The Omagh tragedy, and the subsequent critical independent review, had a significant impact on staff as did the subsequent RQIA inspection of child protection services (Regulation and Quality improvement Authority, 2009) which was, again, highly critical of social work practice in the Omagh area. The staff we spoke to indicated that, within this context, it was very difficult to begin the process of changing the culture of the organisation again and that the focus was on responding to these reviews and attending to practice in the Omagh area;

“That [the Omagh tragedy] just caused such devastation everywhere, how staff felt...the emotions that were around...it was just an awful time everywhere so that took over for a number of years...[RQIA] were on the verge of closing it [Omagh office], they were saying it was so bad...staff were off on sick leave, morale was so low...it was like the Titanic, it was slowly but surely sinking at that stage.”

Immediately prior to the publication of the Toner report, Deirdre Mahon and Tom Cassidy attended a seminar in May 2008 on differential response which was organised by the Children Acts Advisory Board in Dublin with Deirdre Mahon giving a presentation on the ‘New Beginnings’ strategy. At this seminar they met Rob Sawyer and Sue Lohrbach from Olmstead County, Minnesota who were presenting on their agency’s approach to work with children and families called ‘Partnership and Collaboration in Child Safety’. This meeting, and subsequent discussions with Sawyer and Lohrbach, led to an invitation being extended to Deirdre Mahon and Tom Cassidy to visit Minnesota to see the approach in practice. This visit occurred in January 2009 and;

“...reinvigorated a passion in making a change again but in a different way, using an approach and a tool as opposed to a general strategy.”

The approach developed in Olmstead County, Minnesota drew from the ‘Signs of Safety’ approach and Lohrbach and Sawyer had worked with Andrew Turnell, one of the co-creators of ‘Signs of Safety’ over a ten year period in implementing their approach. They had, however, developed the approach further and had, specifically, developed a more detailed and structured version of the mapping framework which accompanies the approach and which is now used within the WHSCT. This was the starting point for the development of SiP in the WHSCT and, in July 2009, a number of staff (Service Managers from Gateway, Family Intervention and Looked after Children’s Services, independent chairs of case conferences, and safeguarding nurses) attended a conference in London at which Andrew Turnell was presenting on the ‘Signs of Safety’ approach. The staff who attended were enthused by this conference and it enabled debate and discussion;

“...the vision was to improve critical reflection, at the baseline of it to engage families and build relationships with them...we needed to build a more skilled workforce to do that...we liked the approach of it. For us it was a great reflective conference because we debated a lot of stuff...There was a lot of what we liked in his [Turnell’s] stuff but also a lot of what we liked in Sue Lohrbach’s...we liked his approach, we liked some of the stuff, we questioned quite a bit of it...”

Following this conference a number of people started trying out some of the ideas and tools associated with the approach although, as the staff we spoke to acknowledged, it was in an uncoordinated way;

“The approach was being dotted around, like the practice principles...There was piecemeal different bits of it all over the place. There was different people trying it and different people doing it.”

Following this conference, Deirdre Mahon and Karen O’Brien attended a week-long training event organised by Gateshead Social Services in September 2009. This course was facilitated by Andrew Turnell and trained ‘Practice Leaders’ who would lead the ‘Signs of Safety’ approach in their organisations and facilitate the mapping of cases using the mapping framework. As already stated, however, the mapping framework used in the WHSCT is the one used by Olmstead County, Minnesota and not the original ‘Signs of Safety’ framework. This training was immediately followed by a visit by Sue Lohrbach to the WHSCT in October 2009 during which she provided training to a number of social work managers, principal practitioners and other professionals from education and nursing. The evolving approach in the WHSCT, drawing from the ‘Signs of Safety’ approach and the one developed in Olmstead County, Minnesota, was named ‘Safety in Partnership’ by the Trust’s Chief Executive towards the end of 2009 and was seen as an appropriate response to recommendations in Toner Report in relation to the need for structured and therapeutically focused work with children and families;

“That’s the part we liked about it, the detail and exploring the impact of problems – we loved that aspect of getting beneath the surface rather than having sweeping generalisations; it was looking at what really was happening and, more importantly, what impact was this having on the children and spelling it out in very simple language...it was a whole systemic approach to it all because it was about looking at supervision, about how we talked to people, how we explained things, how we brought people on board, and how we worked towards making decisions.”

During this period the approach was presented to representatives of the Department of Health, Social Services and Public Safety and the Health and Social Care Board. The staff we spoke to, however, felt that on reflection this had occurred too early in the process as it raised concerns and they didn’t have enough practice examples to illustrate the approach in practice. As already stated, the approach was not being implemented in a coordinated way although it was being overseen by the Trust’s ‘Improving Quality Together Project Board’. The Omagh office was one place in which the approach was being implemented more in totality where Karen O’Brien was, at that stage, acting as Service Manager;

“We started it in team meetings – people brought cases along to the team meetings, focusing on helping the social worker think themselves into and through the case. Staff loved it...We audited every single case in the office and we used different approaches say, for example, there were a number of cases where parents had very low ability and it was very clear that they weren’t grasping or understanding what social workers were worried

about. Utilising the tools of Safety in Partnership, like the Three Houses, we were able to work with families and help them understand what we were worried about and then allow them to tell us what they were worried about..."

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This use of the approach in the Omagh office led to an improvement in morale in that office and, we were told, to feedback from a return visit by the RQIA review team in 2010 which was very positive in relation to the SiP approach. It also led to a realisation that a more coordinated, systematic approach needed to be taken to its implementation across the Trust;

"We were kind of playing around with the implementation at that time and it was clear that we needed a proper implementation plan...learning from the New Beginnings process, we needed a champion and we needed somebody to focus particularly on implementing this throughout the Trust."

In November 2010 Karen O'Brien was appointed as implementation officer for Safety in Partnership (SiP) and remained in that post until April 2011 when she became Assistant Director for Workforce Planning and Governance. At this stage a range of systems, such as the Project Team, Quality Assurance Group, Stakeholder Group and Practice Leaders' Forum, had been established to support and monitor the implementation of SiP with, firstly John Sheridan and, latterly Jennifer McKinney acting as implementation officers in the period from April 2011 to now. It is clear, therefore, that it is only over the last eighteen months that a coordinated approach has been taken to the implementation of SiP in the WHSCT and that the process of implementation is continuing;

"We needed to take a much more structured approach that was implementing it the way we wanted it to be because our fear was that; we were worried that people would just take it and run off with it and interpret it in a different way. We wanted it to be very clear that everything connected and we had one clear interpretation of what we were doing and how we were doing it...so we wanted to bring consistency of practice right across and, to do that, it was a very structured implementation plan with a lead as well – it feels much more structured now than it has done."

6. Conclusion

This report has provided an overview of recent child protection and family support policy and organisational developments in Northern Ireland as the context of the SiP approach in the WHSCT and the theory and evidence base which underpins it. It has also set out the evaluation team's understanding of the approach based on our discussions with staff and review of documents provided by the WHSCT.

As outlined in the preceding section, although the SiP approach has its roots in the legacy Foyle Health and Social Services Trust's 'New Beginnings' strategy, it was developed in response to recommendations in Toner Report (Department of Health, Social Services and Public Safety, 2008) in relation to the need for structured and therapeutically focused work with children and families. The second Toner report (Department of Health, Social Services and Public Safety, 2010) endorsed the principles underpinning the approach but noted that, whilst it had been explained that it was being used in parallel with formal child protection procedures, there was a 'possibility' that it may be used in substitution, or as an alternative, to such procedures. The review panel sought, and received, assurances from the Chief Executive of the WHSCT that SiP would complement rather than replace the existing child protection policy, procedures and processes. The panel also recommended that an evaluation of the implementation and outcomes of the approach be commissioned and the Trust had already started to plan for this

The fieldwork for the second Toner report took place in early 2010 and, as noted in Section 5, the implementation of the SiP approach was then at an early stage. The staff we have spoken to in preparing this report have acknowledged that implementation of the approach was not occurring in a well-coordinated way at this time and, indeed, the senior managers we spoke to indicated that they had concerns that this could lead to inconsistencies in practice. During the course of the preparation of this report, the WHSCT shared with us correspondence received from the Chief Social Services Officer in March 2011 which, whilst indicating that he was reassured that senior managers within the Trust did not consider SiP to be a substitute for the extant child protection policy and procedures, stressed the importance of minimising the risk of misunderstanding by staff as the approach was rolled out across the Trust. Since mid-2011 it is apparent that a much more structured and coordinated approach has been taken to the implementation of SiP in order to ensure consistency of interpretation and practice.

As outlined in Section 4, the publication of *Systematic Review of Models of Analysing Significant Harm* by Barlow et al. (2012) raised reservations regarding the efficacy of the 'Signs of Safety' framework in risk assessment practice and these reservations have been highlighted to the WHSCT via correspondence from the Deputy Secretary (Social Services Policy Group), Department of Health, Social Services and Public Safety and the Director of Social Care and Children, Health and Social Care Board with the Trust again being asked to provide assurances that SiP is not being used as an alternative to child protection processes.

During this phase of the evaluation a number of messages have been articulated about the SiP approach which indicate that the WHSCT has taken appropriate steps, as requested by the Chief Social Services Officer in March 2011, to ensure that the risk of misunderstanding by staff is minimised and that consistency of interpretation and implementation of the approach is promoted. These have been stated clearly and consistently by the staff members we have spoken to and are also reinforced in the documents we have reviewed and in the training that is provided to staff. These can be summarised as follows:

1. SiP is an approach to working with children and families and should not be conflated with the mapping framework that accompanies it. The mapping framework is a tool used within the approach.
 2. The approach is based on clear aims and a set of practice principles which emphasise building constructive working relationships with families and professionals; developing a questioning approach to practice; involving, and communicating with, children and young people; developing a skilled workforce and learning from practice.
 3. The approach is being implemented within the existing child protection policy and procedures and is being used as a complement to existing processes and not as an alternative. The necessity of adhering to existing policies and procedures is highlighted in the first aim of the approach (see section 4).
 4. The implementation of the approach is supported and monitored by a range of systems such as the Quality Improvement Board, Project Team, Quality Assurance Group, Stakeholder Group and Practice Leaders' Forum.
 5. The mapping framework which accompanies the approach is not the 'Signs of Safety' framework but a more structured and detailed development of it (Lohrbach and Sawyer, 2004; 2005) which aims to help workers think through the issues in the case, make decisions about what needs to happen next, and communicate these clearly to families.
 6. The mapping framework is not being used as a risk assessment tool. The framework is used to enable detailed discussion of the case and the concerns involved, decision-making regarding action that needs to be taken, and the communication of these to professionals and family members. Risk assessment occurs before the mapping process and informs the development of risk statements and subsequent safety plans.
 7. The mapping framework, as a tool accompanying the SiP approach, is not being used as an alternative to child protection processes but as a complement to them (see pages 42-46).
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The next phase of work will be a comprehensive realist evaluation of the implementation of SiP exploring whether the assurances provided by the Trust are reflected in practice. This will be achieved by:

- A retrospective case file analysis of 100 cases where SiP has been used and the case subsequently closed in order to explore how the approach is used to complement existing policies, procedures and processes.
 - Focus groups with key groups of staff (social workers, health visitors, teachers, police officers, doctors) to explore whether SiP makes a difference for children and their families and to explore what factors support and impede its use.
 - A prospective, in-depth observational analysis of 20 randomly selected cases where SiP is used to further examine how the approach complements existing policies, procedures and processes.
 - Interviews with the key staff involved in the 20 prospective cases (team leader, social worker, health visitor, teacher, etc.) to discuss how SiP is implemented, whether it meets the needs of the child and their family and how it fits with other types of involvement with the family.
 - Interviews with family members involved in the 20 prospective cases to garner their views on social work practice delivered via the SiP approach.
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